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STATE MEDICAL JOURNAL

VOL. 9 NO. 4

APRIL, 1960

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ANNUAL MEETING—WEDNESDAY, THURSDAY, FRIDAY, APRIL 20, 21, 22, 1960

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## TRUE BROAD-SPECTRUM COVERAGE ...PROVED CLINICAL EFFICACY

In the struggle against sepsis, CHLOROMYCETIN — effective "...against most bacteria, Rickettsia, Treponema, and some viruses..."<sup>1</sup> — has proved a dependable weapon in a variety of infections.

"Over 90 per cent of staphylococci isolated from infections in most institutions are relatively sensitive to chloramphenicol."<sup>2</sup> In a study of a significant number of gram-negative organisms it was found that CHLOROMYCETIN was more effective in *in vitro* sensitivity tests than were other widely used broad-spectrum antibiotics.<sup>3</sup> Moreover, through the years, the incidence of strains of bacteria resistant to CHLOROMYCETIN has remained virtually constant and strikingly low.<sup>4-7</sup>

### IN VITRO SENSITIVITY OF GRAM-POSITIVE ORGANISMS TO CHLOROMYCETIN AND TO THREE OTHER BROAD-SPECTRUM ANTIBIOTICS\*

CHLOROMYCETIN (254 strains)	84%
ANTIBIOTIC A (260 strains)	79%
ANTIBIOTIC B (261 strains)	77%
ANTIBIOTIC C (255 strains)	73%

\*Adapted from Leming & Flanigan.<sup>8</sup>

### EDITORIAL

*This editorial will appear in two parts.*

*Part I represents a brief introductory comment.*

*Part II will cover a more detailed discussion.*

## A Need For Unity Of Purpose In The Medical Profession

*A Statement On Accreditation, Full-Time And Part-Time*

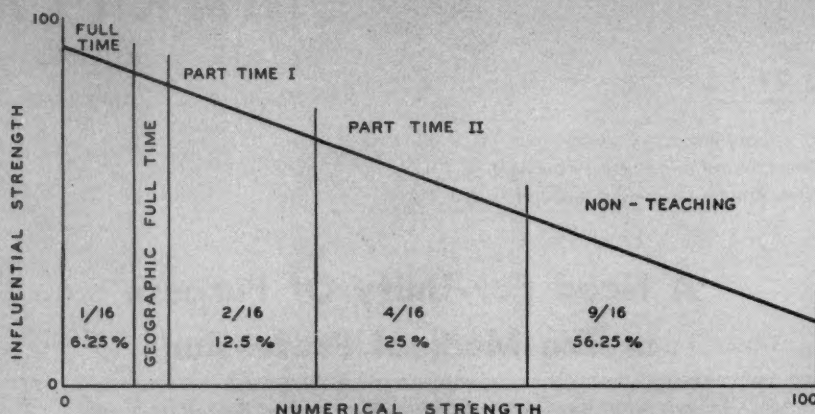
### PART I

AS A RESULT of the directives from Chicago (the Joint Commission on Accreditation and the Council on Medical Education), the smaller hospitals have suffered in many ways. Most of all, they are being made to conform to a pattern which does not differentiate them from the larger hospitals associated with medical schools. Their efforts to comply with the requests made upon them have not been successful in securing their continued accreditation. There seems to be a constant uncertainty from one year to the next regarding their status, their responsibility to their house staff, all of whom are aware of accreditation, and, in fact, their responsibility to the community, since disruption of any kind interferes with successful hospital purpose. It is as if they are to be made to affiliate with larger hospitals; but, in their own judgment, they are becoming satellites of the larger hospitals, and, again, their purpose, which is not basic research, writing of papers and necessarily maintaining professorial status, is being lost. The main purpose of these hospitals is patient care and the training of internes on this basis. This does not exclude research or writing articles, but these are secondary.

The recent upheaval has resulted from a strong implication that every hospital would have a full time director of medical education and that the patients of those doctors who did not teach would not have interne attention. It is generally agreed that the more patients a house officer sees the better trained he will be and that any visiting staff member who prefers not to do formal teaching must be a teacher to some degree. More important, however, is the replacement in some hospitals of the present part-time chiefs by full-time heads of department. There is no indication that this movement is a wave of the future. In fact, many waves of the future have drowned themselves. There is no objection to any hospital which prefers to have a full-time head in any department, but this should not be enforced upon those hospitals which object to it. Furthermore, the movement toward full-time did not come spontaneously.

If every hospital has full-time department heads, it is likely that in time, more and more full-time men will be invited into the hospital, thus changing its complete complexion and, I believe, its purpose. Full-time men are excellent in a hospital environment, but who is to train the young doctor for sick people in the house, granting for the moment that office practice is equally capably performed by both full-time and part-time physicians. In the past it has always been agreed that the part-time men around any teaching institution make a tremendous contribution in time, in knowledge, and in experience, of which the full-time staff are often unaware.

## A CHART WHICH TELLS A STORY; A REFLECTION OF DIFFERENT POINTS OF VIEW



- 1) Rapport good between successive groups but not as good between others.
- 2) The percentages are partly imaginary. The main point to be stressed is the relative strength in influence and numbers.

On the other hand, full-time men have a remarkable knowledge of teaching methods, a brilliant knowledge of the unusual, and it is to them that we look for the major contributions to literature.

After the meeting of the Baltimore City Medical Society on Friday, November 6, I was approached by many practicing physicians who feel that the present movement will possibly exclude them as an important force, not only around the hospitals, but in the profession as a whole. I think this view is perhaps exaggerated, but the schism between full-time men and those who do not teach and the middle group, such as I may represent, is reaching a point at which distrust—which has no place in our profession—is appearing. As I spoke at that meeting, and you will recall that Osler Hall was crowded, it seemed to me that many in the audience (mostly, I believe, those in full-time) did not understand the fact that a small hospital cannot compete with a larger one for house staff, board men, excellence (and perhaps value) of contributions to the literature, and certainly the number of contributions and basic research itself. To convert these smaller hospitals from their real objective, patient care, to make of them satellites or appendages of larger hospitals may be the wave of the future; on the other hand, it may, in its effort to teach more and more and organize better and better, lose sight of the fact that the majority of sick people are interested in a common sense, alert, capable, down-to-earth doctor. Our medical schools cannot take the view that every graduate must be a genius. Many patients would settle for average, workaday doctors who have learned through contact and experience many things not in textbooks. It would be a pity if this latter group, which represents the major component of physicians, would look upon full-time men as, in truth, a group in ivory towers.

A meeting of minds is necessary. There is a unity of purpose in our profession, and a balanced full-time, part-time arrangement is a successful and necessary combination in medical schools and in most hospitals. There should be allowance for variations from this pattern in smaller hospitals which, because they do not wish to conform, become outstanding in their own sphere.

Samuel Morrison, M.D.  
Vice-President, Medical and  
Chirurgical Faculty of Maryland



# MEDICAL AND CHIRURGICAL FACULTY OF STATE OF MARYLAND

## PROGRAM

### 162nd ANNUAL MEETING

APRIL 20, 21, 22, 1960

Mark These Dates

April 1960						
SUN	MON	TUE	WED	THU	FRI	SAT
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17	18	19	20	21	22	23
24	25	26	27	28	29	30

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Mark These Dates

### WEDNESDAY, APRIL 20

#### THE ALCAZAR

2:15 p.m. Congenital Anomalies of the Esophagus. Willis J. Potts, M.D., Surgeon in Chief, Children's Hospital, Chicago. I. Ridgeway Trimble Fund Lecture.

2:55 p.m. Necrology. Leslie E. Daugherty, M.D., President.

3:20 p.m. Psychiatric Aspects of Medical Practice. A Panel Discussion. Moderator—Leo H. Bartemeier, M.D., Medical Director, Seaton Institute, Baltimore.

Participants—Frederick H. Allen, M.D., Professor of Psychiatry, University of Pennsylvania.

M. Ralph Kaufman, M.D., Psychiatrist in Chief, Mount Sinai Hospital, New York City.

### WEDNESDAY EVENING

#### THE ALCAZAR

8:30 p.m. The Biological Effects and Hazards of Ionizing Radiation. A Radiation Symposium. Moderator—Russell H. Morgan, M.D., Professor of Radiology, Johns Hopkins University.

Participants—Donald R. Chadwick, M.D., Secretary, Federal Radiation Council, Washington.

Richard H. Chamberlain, M.D., Professor of Radiology, University of Pennsylvania.

William B. Looney, M.D., Assistant Professor of Radiology, Johns Hopkins University.

### THURSDAY, APRIL 21

#### THE ALCAZAR

9:15 a.m. Current Treatment of Hypertension. A Panel Discussion. Moderator—E. Cowles Andrus, M.D., Associate Professor of Medicine, Johns Hopkins University.

Participants—Edward D. Freis, M.D., Associate Professor of Medicine, Georgetown University. Irvine H. Page, M.D., Director of Research, Cleveland Clinic.

10:15 a.m. Election of the Board of Medical Examiners.

10:40 a.m. Progress in Army Medicine. Lieutenant General Leonard D. Heaton, The Surgeon General, United States Army. J. M. T. Finney Fund Lecture.

11:35 a.m. Stein - Leventhal Syndrome (Polycystic Ovary Syndrome). Robert B. Greenblatt, M.D., Professor of Endocrinology, Medical College of Georgia.

### THURSDAY EVENING

#### SHERATON BELVEDERE HOTEL

6:15 p.m. Cocktails.

8:30 p.m. General Meeting.

Howard M. Norton, Former Chief of Moscow Bureau of the *Sunpapers*, will speak on Assignment Moscow.

### FRIDAY, APRIL 22

#### THE ALCAZAR

9:30 a.m. Chemosurgery of the Basal Ganglia in Parkinsonism, Dystonia Musculorum Deformans and Multiple Sclerosis. Irving S. Cooper, M.D., Professor of Research Surgery, New York University.

10:30 a.m. Atypical Variants of Viral Hepatitis. Gerald Klatzkin, M.D., Professor of Medicine, Yale University.

11:30 a.m. Histaminic Cephalgia: Differential Diagnosis and Treatment. Bayard T. Horton, M.D., Emeritus Staff, Mayo Clinic.

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EXHIBITS

THE ALCAZAR

Nathan E. Needle, M.D., Chairman  
Committee on Scientific Work and Arrangements

## ST. JOSEPH'S HOSPITAL ISSUE

*We acknowledge the efforts of John J. Krejci, M.D. in assembling and editing the scientific papers for this issue of the Maryland State Medical Journal.*

# St. Joseph's Hospital Looks Ahead

**L**ESS THAN THREE years ago the opportunity was offered in these pages to review the history of St. Joseph's Hospital. Between that time and now so much has happened; the march of events has quickened to such an extent that another installment of the St. Joseph's Hospital story is ready to be written. Today St. Joseph's stands on the threshold of new accomplishment and new service in a new building to be constructed in one of the fastest growing sections of the Baltimore suburban area.

As is usually the case where progress is achieved, the hospital had to go through a period of travail before it could gather the strength and determination to take a major step forward. St. Joseph's crisis occurred in December, 1955, when it failed to obtain renewal of its license because parts of the building on North Caroline Street did not meet the Fire Department regulations. This was hardly to be wondered at considering that the cornerstone of the existing hospital was laid in 1871, but it did seem unfortunate that St. Joseph's was going to have to close its doors in a city desperately short of hospital beds and facilities.

A reprieve came through the combined efforts of the medical staff and community leaders. A lay advisory board was formed, representative of various segments of the population, and at considerable expense the fire hazard was eliminated and other improvements were effected. All this was done in full knowledge that the hospital's days were numbered — that the old shell could be patched up to hold together, but that it was basically obsolete, inadequate, and uneconomical.

In the 1958 report issued by the Baltimore Hospital Survey Committee of the Hospital Council, Inc., the statement appeared: "Because of its age and general condition, St. Joseph's Hospital should be replaced." Another point stressed in the report was that the expanding areas outside the city had no general hospitals of their own; thus

**Sister M. Pierre, O.S.F.**  
*Administrator*

it was urged that when new hospitals were created or old ones rebuilt in new locations, sites be selected in the suburbs. Towson, in Baltimore County, was mentioned as a community which, with its neighboring communities, would especially benefit by having a hospital.

Accordingly, the groundwork began to be laid for the inevitable move to the county. M. Oldham Lewis, president of the hospital's advisory board, and T. Gordon Bautz, a board member, served as a committee of two to find a suitable site. They recommended a wooded, gently rolling 28-acre plot near Stevenson Lane, just off York Road at LaPaix Lane in Towson, and this was acquired.

Meanwhile the doctors on the staff of St. Joseph's were making recommendations of their own for the kind of hospital they would like to see built. Their suggestions and those of the board and the hospital administration were passed along to the architect retained to draw preliminary plans; James I. Campbell of Fisher, Nes, Campbell and Associates, Baltimore.

Cost of the construction was estimated at \$8,000,000, and arrangements were made with the New York and Boston firm of fund-raising counsel, Will, Folsom, and Smith, to undertake a campaign with a \$2,000,000 objective. Already set aside for the project by the Sisters of the Third Order of St. Francis, who operate the present 96-year old hospital, was the sum of \$1,000,000. Another \$500,000 is anticipated in a Federal grant. Mortgage loans secured by the Sisters will complete the required total.

The building fund got off to a heartening start last November with more than a quarter of the \$2,000,000 goal pledged or subscribed even before the formal launching of the fund program.

The new St. Joseph's Hospital will rise six stories above the ground floor and contain 322 beds, 81 more than the existing hospital. This will



enable it to care for at least 2,800 more persons a year than at present.

In its design, the building incorporates a number of features which reflect fresh thinking about the comfort and well-being of patients. All service departments are to be confined to the ground and first floors. The second floor will be given over mainly to mechanical equipment and storage space. Patients' rooms will occupy the third, fourth, fifth, and sixth floors. Thus, the second floor will constitute a "buffer zone" between the most active areas of the hospital and nursing units where quiet and absence of traffic are most desirable.

The surgical suite is to include eight operating rooms grouped on either side of a sterile corridor which provides scrub-up and sterilizing facilities. All of the operating rooms also open onto a non-sterile corridor for general traffic.

On the third floor there will be a 36-bed obstetrical unit and a 36-bed gynecological unit. The labor and delivery suite includes six private labor rooms and three large delivery rooms, one equipped for caesarian sections. The delivery rooms will open into a sub-corridor which will serve as a central scrub-up and sterilizing area.

The central corridor plan is again used on this floor for the newborn nurseries. Four 8-bassinet nurseries, a premature nursery, and isolation and suspect nurseries open to a central work corridor to be entered through a gowning area.

The fourth, fifth, and sixth floors each contain two nursing units of 36 beds, for a total of 72 beds per floor. To achieve maximum efficiency in patient care, the dual-corridor plan has been utilized. This concentrates service facilities—nurses' stations, locker rooms, pantry, and storage—in a center core with patients' rooms on either side. In the middle of each floor will be a large solarium, passenger and service elevators, and a service room with dumbwaiter connections to the pharmacy, central supply, and dietary departments downstairs.

Taken floor by floor, the hospital shows an arrangement of all facilities for the smoothest functioning with the least expenditure of time and effort.

Rescued at the very brink of extinction, St. Joseph's Hospital now looks ahead confidently to ground-breaking ceremonies in 1961, and after that, if God is willing, a second century of service.

The irritable colon is a common psychophysiologic reaction of the large bowel to stress and is the cause of much disability, much unnecessary hospitalization, and much fruitless surgery. The irritable bowel syndrome must be considered in all cases of abdominal pain, with or without alteration in bowel habits. The most important single procedure in diagnosis is the recording of a thorough medical history. Physical signs are minimal but significant. Organic disease must be excluded by appropriate radiologic and laboratory studies and by proctosigmoidoscopy. Associated functional symptoms are the rule. Treatment is medical, and consists of measures to relieve emotional stress and to eliminate distressing bowel symptoms. A bland diet is important, especially in the early phases of treatment.

set of the syndrome may not be known to the patient and may even elude careful probing by the alert examiner. The loss of a job, a new job with new and difficult responsibilities, overwork, loss of money or other valuables, a death in the family, domestic problems such as an alcoholic spouse or the knowledge of real or fancied marital infidelity; these and many other stresses may initiate and perpetuate the disease.

Physical factors have often been implicated in the causation or aggravation of the syndrome of the irritable bowel. Mechanical irritants, such as

## THE IRRITABLE COLON

John J. Krejci, M.D.

THE SYMPTOM COMPLEXES of functional diseases are psychophysiologic reactions to emotional stress, are both common and natural, and occur from time to time in most people. These functional syndromes differ in: 1) The basic personality of the patient; 2) The organ or system which reacts; 3) The kind and degree of causal stress; and 4) The degree of severity of the symptoms. When the symptoms become constant enough or severe enough to adversely affect the patient's home and/or job situation, diagnosis and treatment are sought. The irritable colon is one of the principal manifestations of intestinal reaction to an emotionally stressful situation. It is also one of the commonest of human ills, causing the loss of more work hours than any disease other than the common cold, and is undoubtedly the cause of much unnecessary and wasted hospitalization and much explorative surgery.

A definite personality type has been implicated in being particularly predisposed to the irritable bowel syndrome. This is the obsessive-compulsive individual with anal-sadistic traits. Four characteristics mark the anal personality type: first, organization of the personality around the anal region; second, penuriousness; third, obstinacy and meticulousness; and fourth, repressed sadism.

The patient is often well-educated and intelligent, rigid and over-conscientious and characteristically over-reacts to stress. Anxiety and tension are usual. Elements of dependence or guilt may be present but are not essential to the psychophysiologic disturbance. Occupation, social, or economic factors are not constant factors.

The emotional stress which precipitates the on-

laxatives, cathartics and enemata, and chemical irritants, certain foods and beverages, have been held blameworthy. Other factors include poor living habits, overwork, inadequate sleep, irregular meals and poor bowel habits. Associated anorexia, dysphagia, esophageal or pyloric spasm or peptic ulcer may mitigate against good eating habits. Associated hemorrhoids or anal fissure may interfere with normal bowel regularity. In summary, there is reasonable doubt whether these physical factors, mechanical and chemical, are cause or effect. It is likely that they partake of both cause and effect; it is certainly true that habituation to laxatives and enemata as well as the repeated use of irritating foods and beverages will aggravate the disease. It is equally true that the annoying symptoms of the irritable colon will cause the patient to resort to laxatives and/or enemata in an attempt to regulate the disturbed bowel habits and will result in insomnia, poor eating habits with resultant poor nutritional status, and poor bowel habits.

The history is the most important procedure in the diagnosis of the irritable colon. During the history-taking, the examiner must attempt to evaluate the personality of the patient; he must seek to connect a stressful situation with the onset of the syndrome and establish the associated presence of other functional symptoms. The symptom complex of the irritable colon is characterized by variability in severity, location, and time. The most important complaint is abdominal pain, varying from mild distress, a "lump" or "knot" sensation to severe cramping. The pain may locate in the

★ Irritable Bowel Syndrome ★ Spastic Colon ★ Muco-  
Colitis ★ Chronic Functional Colitis ★ Unstable Colon  
★ Cathartic Colitis ★ "Unhappy" Colon ★ Enterocolopathy  
★ Spasmodicorrhoea. ★ Intestinal Neurosis



right upper quadrant, the right lower quadrant, the left lower quadrant, across the infraumbilical abdomen, and in the left upper quadrant. The abdominal distress is intermittent and rhythmic. It may occur daily for a period and then vanish for weeks or months; it is likely to be recurrent. It may appear sporadically during the day; it often occurs at the same time each day. Unlike cholelithiasis and peptic ulcer, the pain is seldom nocturnal. Accompanying the abdominal distress may be a sensation of bloating and distention, nausea and vomiting and borborygmus. In the typical case, all symptoms coincide with increased large bowel activity in the early morning or after meals; in contrast with the typical peptic ulcer syndrome, eating usually intensifies the discomfort. Defecation or passage of flatus provides temporary relief.

Alteration of bowel habits is a constant feature of the disease. The change in bowel function is a reflection of the disturbed motor and secretory activity of the colon and may consist of chronic constipation, bouts of diarrhea, alternating constipation and diarrhea, and changes in the size, shape, consistency, and content of the stool. The stool may be reduced in caliber and is often passed as narrow, segmented masses. At times the feces present the appearance of hard, dry balls. Consistency may vary from a liquid stool with only flakes of feces to a hard, dry, constipated stool. A feeling of incomplete evacuation and a sense of fullness after evacuation often co-exist. Bad bowel habits often cause chronic cryptitis and papillitis, hemorrhoids and anal fissure. The only abnormal content of the stool may be the presence of mucus, and patients often volunteer the recognition of mucus in the stools. Bleeding is not a feature of the disease; however, blood in the stool may result from a coincident and concurrent hiatal hernia, peptic ulcer, intestinal polyp, diverticulum or malignancy, hemorrhoids or anal fissure. A history of gradual, progressive weight loss, which may be extreme, suggests true anorexia nervosa.

Commonly, these patients will manifest: A. tension headaches or migraine-like head pain; B. anorexia nervosa; C. unusual weakness or fatigue; D. insomnia; E. neurasthenia and the effort syndrome; F. vascular instability, as evidenced by flushing, urticaria, dermatographia, excessive sweating, or coldness of the extremities; G. globus hystericus with or without dysphagia; H. esophagospasm, cardiospasm or pylorospasm; I. history

of, or concurrent symptoms of, peptic ulcer; J. urinary frequency; K. functional dysmenorrhea; L. neurodermatitis or pruritus ani or vulvae; M. anorectal cryptitis, papillitis, hemorrhoids and fissures.

Even when the disease is relatively active, the physical examination may be normal. Weight loss may be evident. The abdomen may be distended. Abdominal auscultation may indicate hyperperistalsis. Tenderness may be elicited along the course of the sigmoid colon and descending colon, over the hepatic flexure and along the ascending colon and cecum. There is a fairly constant area of tenderness at the lateral edge of the right rectus muscle, just below the level of the umbilicus. The degree of tenderness is probably an indication of the degree of colonic spasm. After repeated attempts to elicit tenderness, the tenderness diminishes. The spastic or distended cecum may be felt in the right lower quadrant, and the sigmoid colon is often palpated as a ropelike cord, tender or nontender, in the left lower quadrant. Proctosigmoidoscopy may show hyperemic mucosa and increased mucus.

Complete radiologic study of the gastrointestinal tract is always necessary to exclude organic pathology. Cholecystogram may reveal gallbladder disease. The upper gastrointestinal series, including small bowel studies, may or may not show irritability, hyperperistalsis or spasticity. The barium enema is usually normal; distention of the splenic flexure or cecum, spasm of the sigmoid colon or cecum may be noted occasionally. Spastic distortion and irregularity of the cecum, associated with chronic constipation and anemia, has led to the suspicion of carcinoma of the cecum and to, in retrospect, unnecessary abdominal exploration. This is especially likely in view of the notorious difficulty in complete filling and visualization of the cecum with barium. Gastrointestinal spasm on contrast x-ray is an abnormal finding if the barium preparation is at proper temperature and the technique of x-ray examination is properly performed, with satisfactory introduction of the contrast medium and gentle manipulation and palpation of the patient.

Except that stool examination may occasionally show excess mucus, laboratory results are usually normal. Examination of the stool should be conducted for occult blood, ova, parasites, and bacterial culture. Abnormalities of the hemogram, urinalysis, blood chemistry, electrocardiogram,

gastric analysis, biliary drainage, and liver function tests are evidences of unrelated concurrent disease.

The differential diagnosis of the irritable bowel syndrome encompasses a vast variety of diseases. Commonly, however, the syndrome is confused with: A. chronic cholecystitis and cholelithiasis; B. carcinoma of the left and right colon; C. diverticulitis of any portion of the intestinal tract; D. chronic nonspecific ulcerative colitis; E. appendicitis; F. pancreatitis; G. intra-abdominal adhesions, postoperative, inflammatory or congenital; H. mesenteric adenitis (in young patients); and I. dysentery, bacillary or amebic. It should be stressed that many of the diseases involved in the differential diagnosis of the irritable bowel syndrome are surgical diseases. This accounts in great part for the frequency of surgical exploration in patients with symptoms of the irritable colon. The surgeon, by evaluating the personality of the patient and by taking a careful, searching history, should attempt to rule in the diagnosis of the irritable bowel syndrome.

Proper treatment includes measures to relieve mental stress and to eliminate distressful bowel symptomatology.

A thorough history and physical examination and appropriate laboratory and radiologic studies are necessary to rule out organic disease. These negative studies will greatly reassure the patient. The patient will always benefit from a discussion of the nature of functional disease. Reassurance that these functional syndromes are common and natural, that they do not lead to serious organic disease, and that they do respond to treatment may be sufficient at times to relieve symptoms. The understanding physician who allows the patient to ventilate his or her emotional problems practices a helpful superficial psychotherapy; formal psychotherapy may be required for the more difficult cases.

A well-regimented mode of living with adequate work, exercise, and rest must be encouraged. Mental and physical relaxation must be practiced. Offending stresses must be eliminated if possible. Problems at work and at home must be resolved.



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Sedatives are of value in relaxing tensions and inducing sleep and reducing intestinal hypermotility. Tranquilizers may be used to supplement sedation. Regular bowel habits are essential; the patient should set aside a time each morning for defecation, a time free of distraction or interruption.

A low residue, bland diet is essential to good dietary management. The following offending items should be removed from the diet: fried or greasy foods; spices and condiments other than salt; coffee, alcoholic or carbonated drinks, or very hot or very cold drinks; spiced soups, broth, bullion, and chili; bran; coarse cereals and breads; spiced meats, oily or dried fish and meat, pork, veal, and gravy; nuts, pickles; coarse or acid vegetables or fruits, and most raw vegetables and fruits; chocolate in any form. On occasion symptoms may necessitate a liquid and soft diet. Diarrhea, if severe, may require small frequent feedings, five or six a day. Paregoric and kaolin may be used for short periods. Aluminum hydroxide gel may be helpful. Laxatives, cathartics, enemata

and colonic irrigations are definitely contraindicated. The hydrophilic colloids are of value in order to add bulk to the stools and provide mild lubrication.

Severe anorexia or repeated nausea or vomiting will result in marked weight loss with associated nutritional and vitamin deficiencies. Oral supplements of protein, fat, and multiple vitamins are often required to promote positive nutritional balance.

Antispasmodic and anticholinergic drugs are the most useful groups in treatment of the irritable colon in order to decrease hyperactivity of the colon and to relieve pain. Tincture of belladonna and belladonna alkaloids, with or without barbiturates, are the simplest and most efficacious agents. The synthetic anticholinergics are often needed and may be combined with tranquilizers or sedatives.

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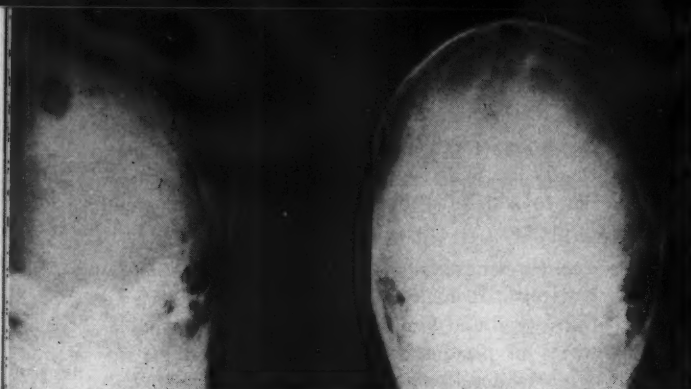


Fig. 1. Left: Roentgenogram showing lesion of eosinophilic granuloma involving the parietal bone posteriorly near the lambdoid suture.

Right: Roentgenogram 17 months later showing almost complete obliteration of the defect.

■ A brief history of the concept of eosinophilic granuloma as related to Letterer-Siwe and Hand-Schüller-Christian disease is presented.

■ A case of eosinophilic granuloma of the skull in a seven-year-old girl is reported.

■ The clinical and pathological features of eosinophilic granuloma are discussed.

## SOLITARY DEFECT OF SKULL (Eosinophilic Granuloma)

A. Andrew Alecce, M.D.

**I**N THE OPINION of many investigators, eosinophilic granuloma, together with Hand-Schüller-Christian disease and Letterer-Siwe disease, is considered a basic disorder of the reticulo-endothelial system. During the past several decades the latter two conditions have been dissociated from the lipid-storage diseases; however, because discussion of eosinophilic granuloma necessarily involves the other "reticulo-endothelioses," I will mention them briefly.

The cases reported by Hand in 1893, Schüller in 1915, and Christian in 1919 were associated with a clinical triad of diabetes insipidus, defects in membranous bones, and exophthalmos, to which these three men's names were attached. Later reports reveal that this triad of events was the exception rather than the rule.

In 1924 Letterer described a non-lipid form of reticulo-endothelial hyperplasia, followed in 1933 by Siwe's criteria of eight clinical and pathological requirements for what he called diffuse reticulo-endotheliosis. Abt and Denenholz proposed the name of Letterer-Siwe disease for the clinical entity of splenohepatomegaly associated with wide-



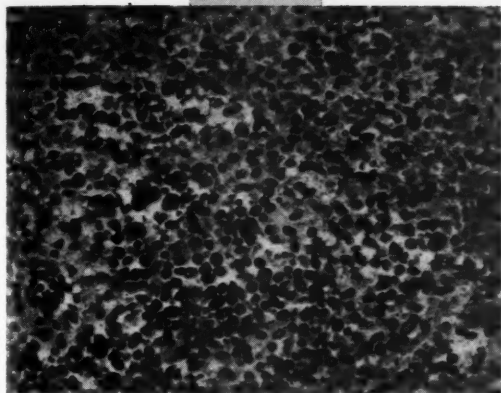


Fig. 2. Photomicrograph (x 400) eosinophilic granuloma: the light shaded cells represent reticulum cells; the darker cells represent eosinophiles.

spread hyperplasia of the non-lipid storing macrophages.

Lichtenstein and Jaffe in 1940 presented cases of solitary bone lesions which they designated "eosinophilic granuloma of bone"; in that same year Otani and Ehrlich described four similar cases under the name of "solitary granuloma of bone." Shortly thereafter emerged three major schools of thought concerning the role of eosinophilic granuloma with relation to Hand-Schüller-Christian and Letterer-Siwe disease. The first group, led by Wallgren, 1940, and Sidney Farber, 1941, concluded that eosinophilic granuloma was not a new disease entity but was identical to Letterer-Siwe and Hand-Schüller-Christian disease. Tracy Mallory, in his experience of five cases, found evidence suggesting that the three diseases were variants of one non-lipid storage disease.

Jaffe and Lichtenstein (7), of the second group, expressing an opinion similar to Farber's (3) concept of a single disease, suggested, "It would still make good sense on clinical grounds to segregate cases of eosinophilic granuloma which is usually limited to one or a few bones and always runs a

benign course from cases of Schüller-Christian disease which often proves fatal." Lichtenstein later (1953) attempted to correlate and integrate these three diseases under the name of Histiocytosis X (8).

Then there were those of the third group, following the views of Otani and Siwe, who insisted that the preceding concepts appear illogical "Because the three diseases show entirely different patterns clinically and anatomically" and should be viewed as entirely separate and distinct entities (14).

It is therefore obvious that the settlement of the confusion and disagreement is contingent on the discovery of the etiology of these three diseases.

Michael and Norcross (12), in 1945, set up the following ten criteria for the diagnosis of eosinophilic granuloma:

1. It is a benign destructive lesion principally affecting the skeletal system, particularly the ribs and skull.
2. It may be unilocular or multilocular in occurrence.
3. It is most common in children and young adults, especially males.
4. Its x-ray appearance of primarily involving the interior of bone and then eroding the cortex, while suggestive of eosinophilic granuloma, is not entirely diagnostic.
5. It probably represents the same basic lipid disorder as Hand-Schüller-Christian and Letterer-Siwe disease.
6. It is probably caused by an infectious agent and its relationship to trauma is purely coincidental.
7. Histologically, it consists mainly of eosinophilic cells, histiocytes, and giant cells.
8. There is occasionally a relatively long interval between the initial and subsequent lesions.
9. It is a benign lesion deserving conservative therapy.
10. Surgical treatment is the procedure of choice although it responds to radiation. Spontaneous healing may occur.

#### PATIENT REPORT

B. L. S., a seven-year-old white female, was admitted to St. Joseph's Hospital on August 26, 1958 with the complaint of a lump in the occipital region of the head. The child first drew the parents' attention to the enlargement two months prior to

admission, when the lump was the size of a pea. The mass gradually enlarged painlessly until the child struck it in a swimming pool on August 10, 1958, from which time she was unable to comb her hair in the occipital area or lie with the mass against a pillow because of the attendant pain and discomfort.

Past history included measles and mumps at the age of four and a tonsillectomy and adenoidectomy three months prior to the present admission.

At the age of 13 her mother had rheumatic fever and "St. Vitus dance." The remainder of the family history was essentially negative.

Physical examination revealed a well-developed, well-nourished child who was comfortable, alert, and unconcerned about her lump. Her temperature, pulse and respirations were normal.

A soft, slightly painful, apparently fluctuant ovoid mass in the occipital region near the midline measured 3 cm. in diameter. An enlarged nontender lymph node was palpable in the occipital group of nodes. The remainder of the physical examination was essentially normal. An admission impression of osteomyelitis of the skull was made.

Laboratory data on admission:

Hemoglobin, 13 grams, 87 per cent; hematocrit, 41 cc.; white blood cell count 11,650 per cubic millimeter with 68 per cent segmented neutrophils, 12 per cent juvenile neutrophils, and 20 per cent lymphocytes; BUN, 9 mg. per cent; blood glucose 92 mg. per cent; serology, negative; urine, trace of glucose, and calcium oxalate and amorphous crystals on microscopic examination.

X-ray examination (fig. 1, left) revealed a radio-lucent area in the occiput apparently representing a Hand-Schüller-Christian disease.

On August 28, 1958 an aspiration biopsy with a 16 gauge needle was performed and was productive of hemorrhagic gelatinous material. Culture of this aspirate was sterile aerobically and anaerobically.

Histologic description was as follows:

The tissue appeared rather homogeneous. There was a broad expanse of macrophages containing irregular foci of eosinophiles, lymphocytes and plasma cells, and an occasional giant cell was seen whose appearance was like a foreign body or osteoplastic type of giant cell. The capillaries were rather inconspicuous. There was one small area of necrosis (fig. 2). On the following day, with the patient under general anesthesia, a six cm. incision

was made extending through the galea and periosteum. The defect in the calvarium measured two by three cms. and was largely replaced by hemorrhagic gelatinous tissue. On curetting both the granuloma and the bone edges, the dura mater became visible. Although slightly indurated, it was apparently uninvolved by the granulomatous process. The wound was thoroughly irrigated with normal sodium chloride solution and sutured with 4-0 dermol.

The curetted tissue was histologically similar to that obtained by biopsy the previous day. A postoperative white blood count revealed a 4 per cent eosinophilia; blood cholesterol, 190 mg. per cent; cholesterol-esters, 105 mg. per cent. An x-ray survey of the chest, long bones, and pelvis was negative.

Sutures were removed on the fourth day after an afebrile postoperative course, and the child was discharged on September 5, 1958, the seventh postoperative day. She continued to have an uneventful recovery. When last seen on January 20, 1960, the occiput was perfectly symmetrical with complete firm healing beneath the surgical scar. The skeletal system has been free of any recurrent "lumps." X-ray examination of the skull on January 20, 1960 revealed almost complete obliteration by bone of the occipital defect (fig. 1, right).

## DISCUSSION

### *Clinical aspects*

Eosinophilic granuloma of bone shows a definite preponderance in males and is found most frequently in children and adolescents, however, it may also occur in adults [one case was reported in a patient sixty one years of age (1)]. Although it is usually monostotic in location, it can occur at multiple sites. Any bone in the body may be involved, but there appears to be a predilection for flat bones. The bones of the hand and feet and the distal radius, ulna, tibia, and fibula are rarely involved. Lesions have been reported in the skin, lungs, and ears.

Symptoms are limited to local complaints of swelling with or without pain with few, if any, generalized manifestations. Lesions of the ribs or calvarium may only present a soft painless swelling, but those of the extremities, particularly in the region of joints, may be associated with stiffness or limping. A few days to several months may elapse before a patient seeks medical attention.

Otani, Ehrlich, and Farber (3, 14) feel that trauma has a definite place in the etiology; however, many other investigators find no evidence to confirm this.

Lichtenstein and Jaffe demonstrated an eosinophilia of four to ten per cent in many of their cases, but others do not substantiate this except in isolated instances. Leukocytosis with no change in the differential count and a low grade fever is common. Blood cholesterol, cholesterol esters, total lipid, phosphorus, calcium, and phosphatase are all within normal limits. Cultures for bacteria and viruses are also negative. No Bence-Jones protein has been found in the urine.

#### *X-ray findings*

On roentgenographic examination, the lesion appears as a small or large round, oval, or irregular radiolucent area. It arises in the interior of bone involving the adjacent cortex as it enlarges by expanding or eroding it. The same picture may be produced by multiple myeloma, primary or metastatic carcinoma, syphilis, tuberculosis, Ewing's tumor, osteomyelitis, chondroma, and giant cell tumor.

#### *Pathology*

Grossly this lesion appears as a reddish hemorrhagic gelatinous mass containing areas of necrosis. The histologic pattern is that of a "chronic inflammatory proliferation of the histiocytic cells of the reticulo-endothelial system together with an associated proliferation of fibroblasts, an infiltration of white blood cells," and an accumulation of foreign body giant cells (15). The presence of eosinophiles in large numbers gives this lesion a striking appearance, although this is characteristic of any long standing chronic inflammation and is not a basic constituent of the disease. This eosino-

philia, both in the lesion and in the peripheral blood, which is considered by many pathognomonic of eosinophilic granuloma, is occasionally a feature of Hand-Schüller-Christian disease. On the other hand, the diagnostically important foam cells of Hand-Schüller-Christian disease have been absent in a considerable number of cases and may occasionally be found in eosinophilic granuloma (3). Both these diseases may be associated with varying degrees of fibrosis. One can therefore understand why so much disagreement and perplexity exists concerning the identity or distinctness of the reticuloendotheliosis.

#### *Treatment*

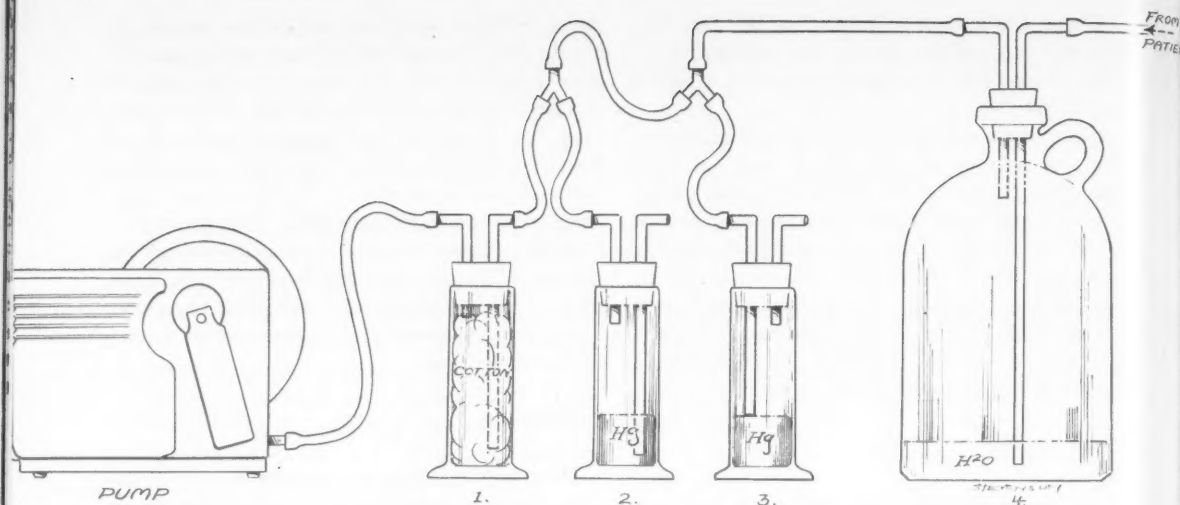
Most of the lesions of eosinophilic granuloma show complete regression and healing after simple surgical curettage or x-ray therapy. In the cases of multilobular disease, radiation therapy is preferred after a diagnostic biopsy of one lesion is performed. An occasional untreated granuloma can heal spontaneously through resolution. This benign course is in definite contrast to the invariably rapidly fatal outcome of Letterer-Siwe disease and the more benign but nevertheless frequently fatal Hand-Schüller-Christian disease, whose lesions tend to become "scarified, collagenized, and lipidized (7)."

The case presented in this report retains enough of the features of the so-called eosinophilic granuloma (monostotic lesion in a seven-year-old child with eosinophilia that responded to simple curettage and presenting a histological picture of histiocytes, eosinophiles, giant cells and necrosis), that I have arbitrarily designated it as such. Only time will tell whether new lesions will appear and whether this already is or will progress to Hand-Schüller-Christian disease.

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## A Method of Control and Indication of Negative Pressure Suction Drainage

*A simple negative pressure suction drainage apparatus is described and illustrated.*

Otto C. Brantigan, M.D.

AS LONG AS open thoracotomy has been practiced, drainage of some type has been used at the completion of the operative procedure. Only on rare occasions was the chest closed tight without drainage. Because of the elastic quality of the lung, with its tendency to collapse, either the chest had to be closed tight without drainage or an underwater seal type of drainage had to be used. About 20 years ago a negative pressure suction was added to the underwater seal type of thoracic cavity drainage. Although it is difficult to be cer-

tain, negative pressure suction now appears to be universally used after thoracic surgery.

The drainage of operative wounds undoubtedly was imperative in ancient times, but as surgical technique and control of infection were improved, a tendency developed to abandon the drainage of clean elective operative wounds. Certain wounds are particularly known to exude serum, tissue juices, and/or lymph and are drained to remove such fluid rather than because of the fear of infection. Notable among these surgical wounds are those following radical neck dissections, radical mastectomy, radical inguinal node dissections, excision of panniculus adiposus abdominus, and sometimes large recurrent abdominal hernia. Any large surgical wound may require drainage. In 1953 Lattimore and Koontz\* reported their work of negative pressure suction drainage applied to large hernias where tantalum had been used. Nega-

\*Lattimore, T. J. and Koontz, A. R., Suction Drainage After Implantation of Tantalum Gauze Sheets: JAMA 155:1333-1334, 1954.



FROM  
PATIENT

Fig. 1.—Stedman Pump. Any source of negative pressure suction can be used: water faucet, steam radiator, thermatic suction, or other types of electric suction motors. Two or more Stedman pumps can be connected together.

1. Trap bottle filled with cotton. This prevents the draining of fluid and/or mercury into the source of suction. Such material may obstruct the suction pump.

2. Mercury manometer. It is made from any wide mouthed bottle or, as illustrated, an ordinary thermometer holder, a two hole rubber stopper, and glass tubing appropriately bent and cut to proper length. The bottles should be relatively small so that a large volume of mercury will not be needed. If rubber tubing is connected, as shown in the drawing, the amount of negative pressure will be determined by the distance to which the open glass tube is depressed under mercury. It can be regulated to any level from a few millimeters to about five centimeters of mercury, depending upon the size of the bottle used.

3. Safety valve and indicator of the amount of negative pressure. As in 2, the manometer is made with the same materials. The open glass tube is away from the mercury. The glass tube connected to the rubber tubing system is allowed to rest on the surface of the mercury. If a positive pressure develops in the system air can be exhausted by one millimeter or less of mercury of positive pressure, since the glass tube merely rests on the top of the mercury. When a negative pressure develops in the system the mercury will be drawn up into the glass tube to a point equal to the distance of the glass tube in manometer 2, beneath the surface of mercury. This unit is a pop-off valve preventing a positive pressure and an indicator or gauge registering at all times the amount of negative pressure within the system.

4. Underwater seal drainage bottle. A gallon bottle or jug is a good size to use. It requires a two hole stopper and glass tubing as illustrated. The underwater seal is important as a safety measure when used for chest drainage. If the apparatus is intact between the patient and the underwater seal drainage bottle, the apparatus can be disconnected beyond the underwater seal drainage bottle or the suction will fail completely, and yet no air can be drawn into the chest or the wound being drained. The underwater seal bottle, its contents and the tubing leading to the patient should be sterile so that the wound or chest cannot become contaminated if the contents should inadvertently get into the wound or chest. When a fair volume of air is drawn through this underwater seal drainage bottle, foaming and bubbling in the bottle may be prevented by adding a small amount of alcohol or an antifoam agent.

tive pressure suction drainage of selected clean surgical wounds has become widely used.

Many years of use have proved the merit of adding negative pressure suction to underwater seal drainage of the thorax that has been opened. Years of practical application have proved the benefits derived from adding negative pressure suction drainage to large surgical wounds that characteristically exude serum, tissue fluid, lymph, or even blood. The amount of negative pressure suction applied to the underwater seal or to the wound drainage tube should be accurately controlled. There have been developed a number of commercially available negative pressure suction systems which will accomplish what is claimed for them. The commercially available negative pressure suction equipment is expensive and complicated. Water, invariably used as the unit of measure, is satisfactory for fine measurement, but for general use in suction applied to the thorax or to surgical wounds, water is too small a unit of pressure and is, therefore, not flexible enough to provide sufficient negative pressure in many instances. Since mercury is approximately 13 times heavier than water, it will permit a wide range of pressure variations by use of a short column of mercury; for example, four centimeters of mercury negative pressure will equal a water column of about 52 centimeters.

Presented here is a cheap, simple manometer system (fig. 1) that uses mercury. This measuring device has been in use at least 20 years and has adequately proved its merit. The suction can be applied from any source, but in most instances the inexpensive durable Stedman pump will provide sufficient suction. This pump will deliver sufficient negative pressure for all occasions; however, in some instances the volume of suction per minute is insufficient for the thoracic cavity drainage. When a greater volume per minute is needed, other sources of suction, such as water faucet suction, radiator suction, and other types of electric-driven suction motor pumps, can be used; or one can even connect two Stedman pumps together.

The manometer device consists of a positive pressure and a negative pressure measuring manometer (fig. 1: 2, 3). In the system there is an underwater seal bottle (fig. 1: 4) to collect drainage material from the wound or chest. In chest drainage this unit is a safety measure that will not allow air to be drawn into the chest if the suction mechanism fails. There is a trap bottle (fig. 1: 1)

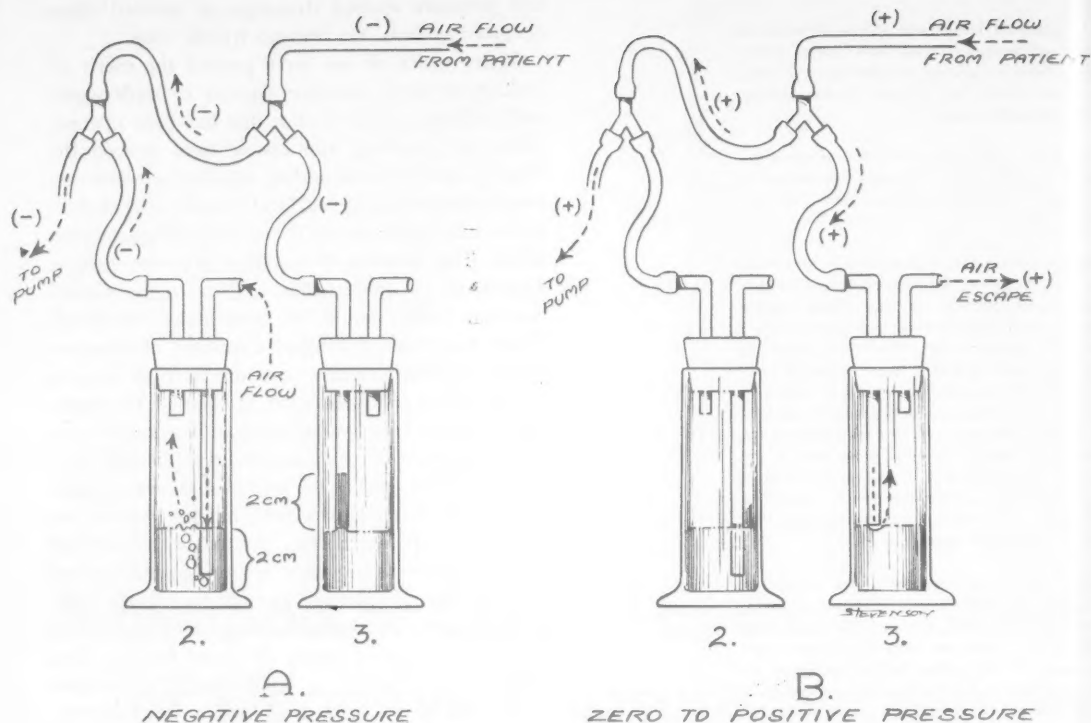


Fig. 11

A. A demonstration of the effects of negative pressure. The amount of negative pressure permitted in the system depends upon the distance the open glass tube is under the mercury in manometer (2) and it is indicated by the height of the mercury drawn into the glass tube in manometer (3).

B. An illustration of the pop-off valve effect or exhaust valve effect of manometer (3). It will not allow a positive pressure to develop in the system.

to prevent mercury and/or fluid from entering the source of suction and perhaps impairing the source of suction. The manometer that controls the amount of negative pressure is rather simple, as shown in fig. 1: 2, and can be adjusted to any level from a few millimeters to five centimeters of mercury by regulating the distance to which the glass tube is depressed under the surface of the mercury. The manometer that serves as a safety mechanism preventing a positive pressure in the system (Fig. 1: 3) also acts as an indicator or gauge of the amount of negative pressure in the system. In this manometer the glass tube is allowed to merely rest on top of the mercury. If a positive pressure develops within the system it is exhausted by one millimeter of mercury or less. The volume of air thus exhausted per second will depend upon the capacity of the rubber tube system. The manometer system herein described is not a closed system. In chest drainage it is imperative to avoid a system in which positive pressure can be built up if the suction should fail or if the volume of suction per second does not equal or exceed the air leak from the lung. In any suction apparatus it is comforting to the surgeon to be able to determine at a glance the amount of

negative pressure suction that is being applied. The mercury manometer can be constructed from any wide mouthed bottle or thermometer holder, a two-holed rubber stopper and glass tubing. The bottle used should not be too large, merely because it would require too much mercury.

The tubing leading from the patient and the underwater seal drainage bottle should be sterile at the beginning and kept sterile in order that, by any circumstance of mishap, unsterile fluid from the underwater seal drainage bottle could not reach the chest or the wound being drained. Nothing need be sterile beyond the underwater seal drainage bottle.

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# HYDROXYZINE THERAPY

## of Cardiac Dysrhythmia

Antonio D. Talusan, M.D.

A STATE of relative coronary insufficiency may occur during tachycardia (1) as a result of the increased nutritional demand on the myocardium due to the increased work of the heart. It may occur even though the coronary arteries are normal. In premature auricular and ventricular extrasystoles the coronary blood flow may be reduced to as low as 25 per cent of the normal coronary flow if the premature extrasystoles are frequent. Paroxysmal supraventricular tachycardias and rapid auricular fibrillation will decrease the coronary blood flow to about 39 per cent. In ventricular tachycardia the coronary blood flow is reduced to 59 per cent, and in ventricular fibrillation there is no coronary blood flow at all. In patients with abnormal coronary arteries and an ischemic myocardium, the presence of these various forms of cardiac arrhythmia, if not terminated promptly, may result in myocardial infarction or even in death. Cardiac arrhythmias increase the mortality rate in myocardial infarction (2); hence the necessity of utilizing an effective but safe antiarrhythmic agent cannot be overemphasized.

Digitalis is not a safe drug to use in cardiac arrhythmias because it increases myocardial excitability and the likelihood of aggravating further the tendency to ectopic mechanisms (3-4). Another injunction against the use of digitalis is that toxic doses may give rise to ventricular tachycardia and subsequent ventricular fibrillation. Pronestyl® and quinidine are effective drugs for the treatment of cardiac arrhythmias, especially the ventricular forms, but if given intravenously, these drugs may give rise to a hypotensive reaction or heart block.

Burrell et al (5) reported the use of hydroxyzine in 50 patients with various forms of cardiac arrhythmia and concluded that hydroxyzine is a safe, easily administered, non-toxic therapeutic tool. The results were excellent in 30 cases. Since the publication of this report, we have treated our arrhythmic patients with hydroxyzine and present here a report of ten patients with various forms of cardiac arrhythmia treated with hydroxyzine.

*From the small series of cases presented, it is suggested that hydroxyzine is a potent, safe, and easily administered antiarrhythmic agent. Its mechanism of action is not known. It is effective in both auricular and ventricular arrhythmias, but the ventricular types respond in a more dramatic fashion. Since no contraindication to the intravenous administration of hydroxyzine in the dosage used in this study has been reported, it appears warranted to administer hydroxyzine in urgent situations without waiting for the electrocardiograph diagnosis of the arrhythmia.*

### MATERIALS AND METHOD OF STUDY

Patients with the presenting symptom of cardiac arrhythmia were selected from the inpatient medical service and accident room service. \*Some patients were already receiving quinidine, Pronestyl®, and/or digitalis before admission for previous attacks of arrhythmia or because of congestive failure. Admission electrocardiograms were taken. After the diagnosis of the cardiac arrhythmia had been established, patients were given hydroxyzine intravenously, 50 mg. initially and repeated as necessary. If after 150-200 mg. of hydroxyzine intravenously had been given there was no response, quinidine, Pronestyl®, and/or digitalis were given intravenously. Serial electrocardiographic tracings were taken during the treatment and on subsequent follow-ups. After the conversion of the arrhythmia to normal sinus rhythm or

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to a more desirable rhythm, patients were given oral hydroxyzine and/or digitalis, or quinidine, or Pronestyl®, as indicated in the individual case.

#### RESULTS

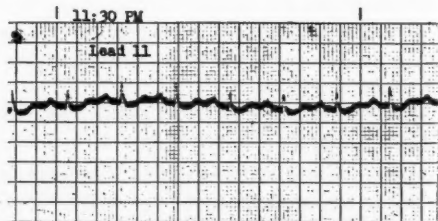
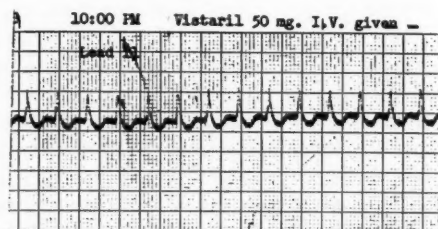
Nine out of ten patients in this series with cardiac arrhythmias responded satisfactorily to the administration of hydroxyzine intravenously. Case 6 responded after the administration of digitalis intravenously, but it is felt that the hydroxyzine might have played a part in the result because the change in rhythm was too fast to be attributed solely to digitalis. Case 10 did not change rhythm until the next day following therapy with hydroxyzine and after having been given digitalis orally; however she responded clinically to the extent that she developed a slower ventricular rate, breathed better, and regained consciousness. She received the digitalis orally and had just received one-half the digitalizing dose of digoxin. It is felt that in this case also the hydroxyzine might have played a part in the conversion to a normal sinus rhythm.

## *Illustrative*

### *Case*

### *Summaries*

**Case I** G. C., a 50-year-old white male, was admitted to the accident room because of palpitation, shortness of breath, and profuse sweating. He had been having recurrent bouts of paroxysmal tachycardias for the past 20 years, and had been on various forms of therapy, including digitalis, quinidine, sedatives, carotid sinus and eyeball massage; but the tachycardia continued to recur. He was on quinidine prior to his coming to the accident room. He had also tried carotid sinus and eyeball massage but to no avail. His initial electrocardiogram showed supraventricular tachycardia with a ventricular rate of 170 beats per minute. He was given 50 mg. of hydroxyzine intravenously. Ninety minutes later the rhythm reverted to normal sinus, whereupon he was discharged and maintained on oral hydroxyzine.

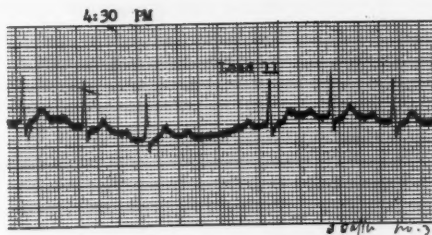
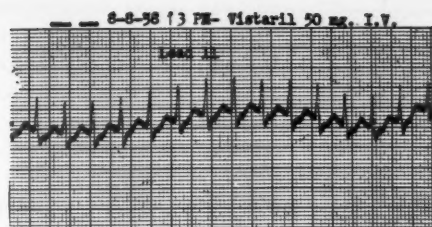


Upper tracing showed paroxysmal supraventricular tachycardia. Lower tracing showed normal tracing after the intravenous injection of 50 mg. of hydroxyzine.



## Case 2

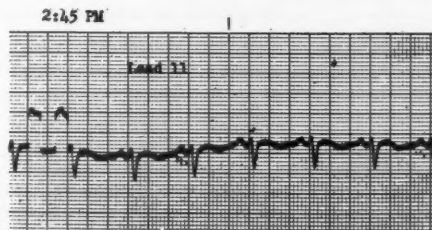
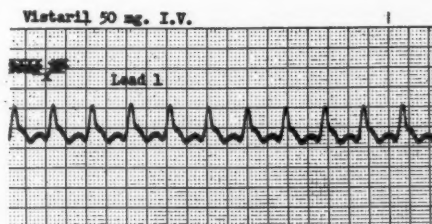
F. R., a 51-year-old white male, was admitted to the accident room because of palpitation, shortness of breath, and general body weakness. He had been having recurrent attacks of palpitation for the past three months. During one of these attacks he had an electrocardiogram done, which showed paroxysmal supraventricular tachycardia. He was given oral quinidine and had been on quinidine since. His admission electrocardiogram revealed supraventricular tachycardia with a ventricular rate of 180 beats per minute. He was given 150 mg. of hydroxyzine intravenously in three divided doses, and 90 minutes later his electrocardiogram showed normal sinus rhythm. He was discharged on quinidine.



Top tracing showed paroxysmal supraventricular tachycardia. Bottom tracing showed normal sinus rhythm after the administration of 150 mg. of hydroxyzine intravenously.

## Case 3

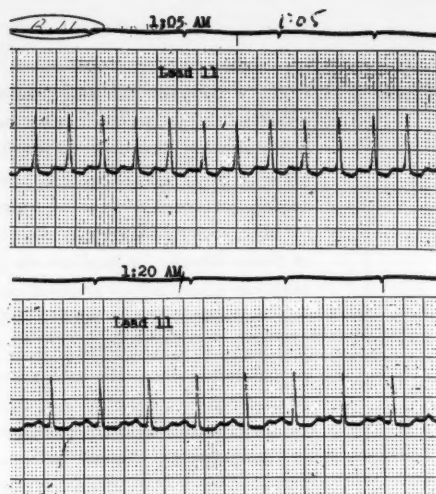
F. H., a 55-year-old white male, was admitted to the hospital because of acute anterior myocardial infarction. In addition to the acute myocardial infarction pattern, his admission electrocardiogram revealed paroxysmal ventricular tachycardia. He was immediately given 50 mg. of hydroxyzine intravenously, and in 45 minutes he reverted to normal sinus rhythm. He was maintained on oral hydroxyzine.



Upper tracing showed paroxysmal ventricular tachycardia. Lower tracing showed normal sinus rhythm taken after the intravenous administration of 50 mg. of hydroxyzine.

**Case 4** R. J., a 56-year-old white female, was admitted to the hospital because of tachycardia and shortness of breath. She had been having recurrent bouts of paroxysmal tachycardia for the past 15 years. Her initial electrocardiogram revealed supraventricular tachycardia with a ventricular rate of 170 beats per minute. She was given 100 mg. of hydroxyzine intravenously in two divided doses, and 20 minutes later she had a normal sinus rhythm. She was maintained on oral hydroxyzine.

The top tracing was taken before treatment and it showed paroxysmal supraventricular tachycardia. The bottom tracing was taken after the injection of 100 mg. of hydroxyzine intravenously and it showed normal sinus rhythm.

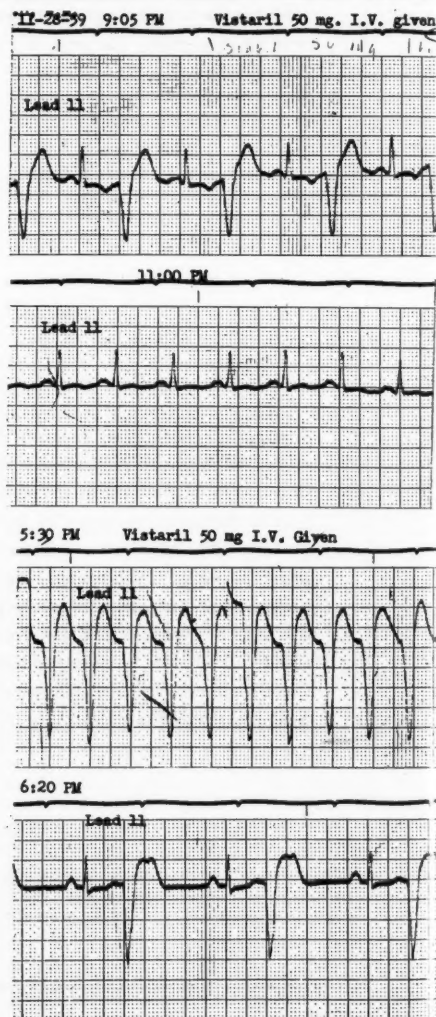


**Case 5** F. B., a 42-year-old white male, was admitted to the hospital because of shortness of breath of one month's duration. He had rheumatic heart disease during childhood. His admission electrocardiogram showed frequent ventricular premature beats and bigeminal rhythm (A). He was given 50 mg. of hydroxyzine intravenously for three doses and after 105 minutes the frequent extrasystoles disappeared. He was then

A. Top tracing showed frequent ventricular premature beats in a bigeminal fashion. Bottom tracing showed normal sinus rhythm and the disappearance of the frequent ventricular premature beats after the injection of 150 mg. of hydroxyzine intravenously.

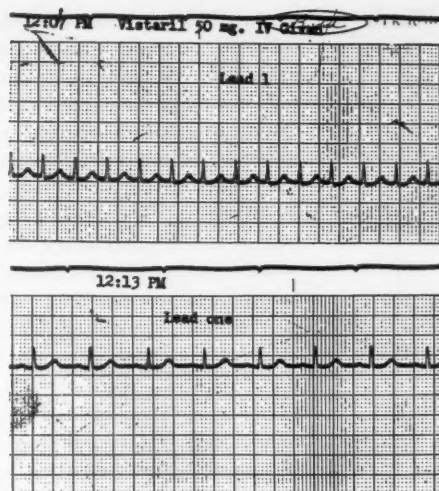
maintained on oral hydroxyzine. Two days later the frequent ventricular extrasystoles were noted. Because he was in failure he was digitalized and given quinidine orally. On the eleventh hospital day, he developed paroxysmal ventricular tachycardia (B). Hydroxyzine 50 mg. intravenously was given, and 15 minutes later he already had a normal sinus rhythm with frequent ventricular premature beats.

B. Upper tracing showed paroxysmal ventricular tachycardia. Lower tracing showed normal sinus rhythm with frequent ventricular premature beats after the administration of 50 mg. of hydroxyzine intravenously.



# Case 6

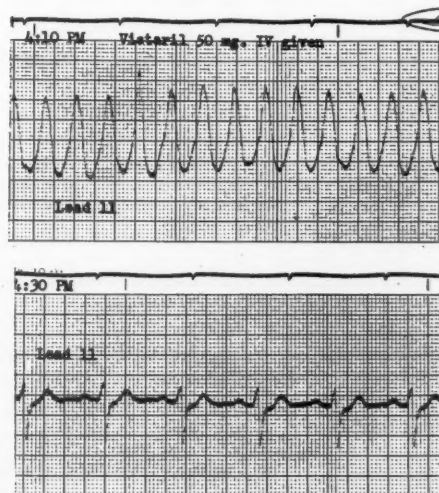
C. D., a 47-year-old white female, was admitted to the hospital for possible myocardial infarction. She gave a rheumatic fever background. Her admission electrocardiogram was suggestive of an acute posterior wall infarction. On the sixteenth hospital day, she developed a paroxysmal supraventricular tachycardia. She was given hydroxyzine 50 mg. intravenously for two doses. One hundred minutes later her rhythm was still unchanged, so she was digitalized with Cedilanid® intravenously. Thirty minutes after the administration of digitalis she reverted to normal sinus rhythm.



Upper tracing showed paroxysmal supraventricular tachycardia. Lower tracing showed normal sinus rhythm after the administration of 100 mg. of hydroxyzine intravenously and 0.8 mg. of Cedilanid® intravenously.

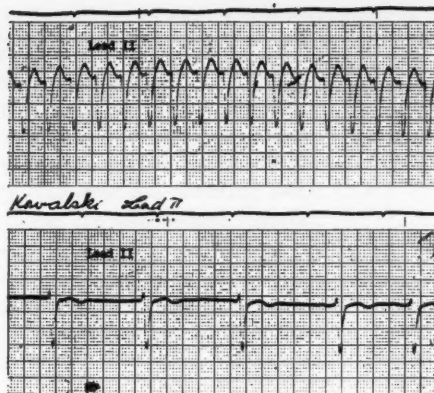
# Case 7

I. M., a 42-year-old white female, was admitted because of shortness of breath. She had been on digitalis for the past 15 years for rheumatic heart disease. Her admission electrocardiogram showed a normal sinus rhythm, first degree A-V block, left ventricular hypertrophy and strain, and digitalis effect. Digitalis was withheld for three days. The P-R interval returned to normal limits, so digitalis was resumed. On the seventh hospital day she developed paroxysmal ventricular tachycardia, which was successfully treated with hydroxyzine and intravenous procaine amide. Oral procaine amide and hydroxyzine were subsequently administered. Four hours later she had another bout of paroxysmal ventricular tachycardia and was given 50 mg. of hydroxyzine intravenously. Twenty minutes later she reverted to normal sinus rhythm.



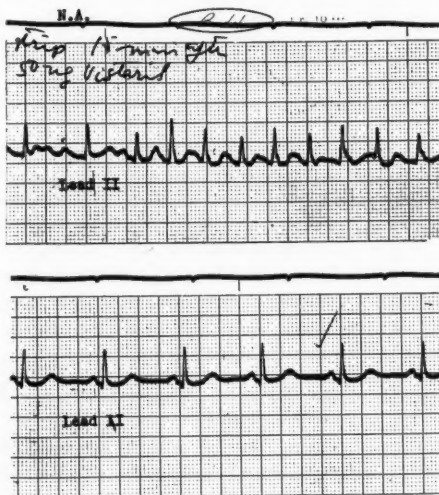
Upper tracing showed paroxysmal ventricular tachycardia. Lower tracing showed normal sinus rhythm after the injection of 50 mg. of hydroxyzine intravenously.

**Case 8** R. K., a 75-year-old white male, was admitted for possible acute myocardial infarction. He was in chronic heart failure and had been receiving digitalis. On admission an electrocardiogram was taken which showed auricular fibrillation, complete right bundle branch block, left and right ventricular hypertrophy, and digitalis effect. On the sixteenth hospital day he developed supraventricular tachycardia. After 150 mg. of hydroxyzine intravenously in three divided doses at hourly intervals, the rhythm was successfully converted to auricular fibrillation with a slow ventricular rate. He was then given oral hydroxyzine. The next day he again had a paroxysmal supraventricular tachycardia and was started on quinidine.



Upper tracing showed paroxysmal supraventricular tachycardia with complete right bundle branch block. Lower tracing showed auricular fibrillation, complete right bundle branch block, with a slow ventricular rate. This was taken after the administration of 150 mg. of hydroxyzine intravenously.

**Case 9** N. A., a 56-year-old white female, was admitted because of palpitation. She had been on quinidine for five days prior to admission. Admission electrocardiogram was suggestive of auricular fibrillation with a ventricular rate of 110 beats per minute. Intravenous hydroxyzine 50 mg. was given, and in two hours the rhythm changed to normal sinus. She was maintained on oral hydroxyzine.



Upper tracing showed paroxysmal auricular fibrillation. Lower tracing was taken after the administration of 50 mg. of hydroxyzine intravenously and it showed normal sinus rhythm.

**Case 10** C. W., a 62-year-old white female, collapsed at work and was admitted to the hospital. She has a known case of pernicious anemia and still receives Vitamin B<sub>12</sub> injections regularly. An electrocardiogram taken on admission showed auricular fibrillation with a ventricular rate of 188 beats per minute. She was given 150 mg. of hydroxyzine

intravenously in three divided doses and slowed down to 150 beats per minute. She improved clinically. The next day she was still fibrillating and was digitalized orally. With just one-half the total digitalizing dose, the auricular fibrillation was converted to normal sinus rhythm. She was maintained on oral hydroxyzine and digitalis.



## DISCUSSION

These cases suggest that hydroxyzine is of value in the treatment of cardiac arrhythmias, which is in accord with the experiences of previous workers (5). It is not only effective in ventricular forms of arrhythmia, but in auricular forms as well, although the response of the ventricular forms of arrhythmias is more dramatic compared to that of the auricular types.

Hydroxyzine is an effective ataractic agent which has been shown to be a potent antiarrhythmic agent. The mechanism of action is not definitely established, but it has been postulated that it might possess a direct myocardial effect. The rapidity of action of the drug tends to support this theory. Other ataractic drugs do not seem to have this antiarrhythmic property. It might be theorized that because of its calming and sedative effect, the primary site of action is the central nervous system, and this is the basis for the conversion of the arrhythmia to normal or a more desirable sinus

rhythm. Most of the patients in this series had been treated with barbiturates, tranquilizing drugs other than hydroxyzine, and narcotics without beneficial effect.

It appears that hydroxyzine given orally and for prophylactic purposes is not an effective antiarrhythmic agent. Most of our patients developed cardiac arrhythmias while on oral hydroxyzine.

All but one of the patients in this series received anticoagulant therapy. No difficulty was encountered in the control of the prothrombin time. The anticoagulant requirement did not seem to be affected in contrast to the experience of previous investigators.

There has been no embolic phenomenon encountered in this series and in the series of Burrell et al (5). Embolization is not uncommon in arrhythmic patients treated with digitalis and/or quinidine.

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## Newly Licensed Physicians

At a reciprocity meeting on February 19, 1960, the Board of Medical Examiners licensed the following physicians to practice medicine and surgery in Maryland:

Austin, Perry G. M., Jr., National Board  
Austin, Theodore Roe, Tennessee  
Bowers, Malcolm Baker, Jr., Missouri  
Cockerille, Laurence Lee, District of Columbia  
De Vita, Michael Richard, National Board  
Duker, Daniel Gregory, Pennsylvania  
Eichler, Myron Franklin, National Board  
Faris, Marion Dees Miller, Virginia  
Flotte, Camille Thomas, Pennsylvania

Gordon, John Norris Curry, California  
Hansen, Fredrik Christian, Jr., National Board  
Jaffee, Irwin Sidney, National Board  
Johnson, Harold Ray, Pennsylvania  
Kelly, Edward Burke, District of Columbia  
Kramer, Robert Allyn, National Board  
Legler, Glenn Duane, Wisconsin  
Littlejohn, Thomas Chlingman, Jr., Georgia  
Noone, Paul Taylor, National Board  
Odell, Gerard Berlage, National Board  
O'Neill, Patricia Ruth, California  
Reames, Patrick Martin, Texas  
Roark, George Wheeler, Jr., Kansas  
Seidel, Jerry Glenn, Illinois  
Smith, Joshua Augustus, California  
Snyder, Maria Cristina B. de Melle, National Board

# Benign Tumors of the Ampulla of Vater

Alberto Zapata, M.D.

*"There is probably no position within the body outside of the central nervous system where a growth while yet so small, is heralded by more widespread symptoms than at the lower end of the common bile duct."*

(Wycott 1912—Kyle 1950)

**B**ENIGN TUMORS of the ampulla of Vater are rare.<sup>(5)</sup> The frequency of such neoplasms is low, and only a few have been described in individual series. (Kirsteins described 12 in 1953.) They may arise in the distal end of the common bile duct or the pancreatic duct and only secondarily invade the "Papilla of Vater." The site of origin is not always possible to determine; the tumor may have originated in the common bile duct, in the papilla itself, or in the duodenum proper.

Such a tumor starts to produce symptoms only after it has caused obstruction of the common bile duct and/or the pancreatic duct, which symptoms will be similar to those of carcinoma of the ampulla of Vater.<sup>(5)</sup> When the obstruction is gradual, the proximal tributaries, including the intrahepatic biliary ducts, become dilated with the eventual production of "white bile"—"hydrohepatosis."<sup>(1)</sup> This is a difficult diagnosis to make, and frequently can only be made upon transduodenal exploration.<sup>(2)</sup> The symptomatology is not characteristic, but certain manifestations may suggest the type of lesion. Biliary dyspepsia is a common complaint, suggesting gallbladder pathology.

Marinaccio<sup>(5)</sup> described in his cases episodes of intermittent pain in the epigastrium and right upper quadrant with little change in the general condition of the patient. He explained these symptoms as episodes of cholangitis with spontaneous and prolonged remissions.

These tumors usually do not completely occlude the passage of bile into the intestines; however, there is some back pressure, due to partial obstruction of bile flow, which may result in the gradual dilatation of the bile ducts and gallbladder. Occasionally the gallbladder may be palpable. Jaundice frequently develops and may fluctuate to some degree; however, the jaundice is usually less intense than that associated with obstruction due to stone or to malignant disease. Pruritus is less often seen as an associated symptom.<sup>(5)</sup> Bleeding from the lesion may lead to a rather persistent secondary anemia, the origin of which is difficult to determine. Blood may be found in the stools, but gross bleeding is infrequently noted.

Laboratory studies are generally of little value in establishing the differential diagnosis.

The jaundice produced by these tumors may be difficult to differentiate from hepatocellular jaundice.

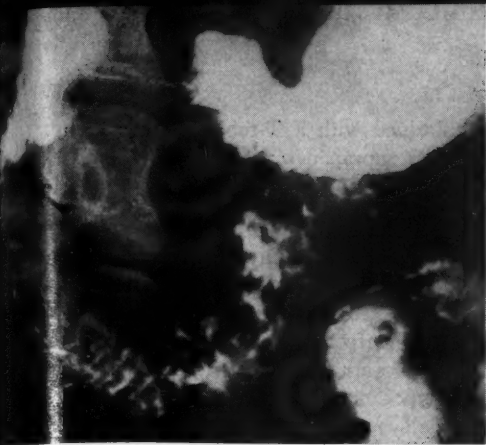


Figure 1



Figure 4

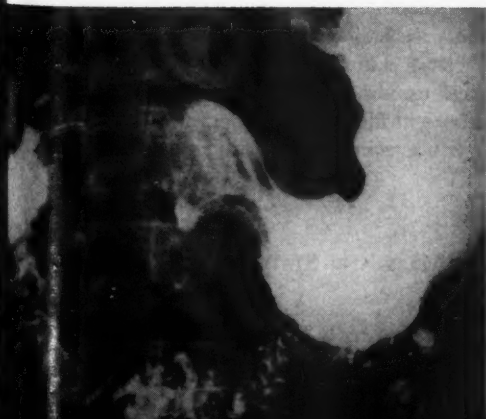


Figure 5

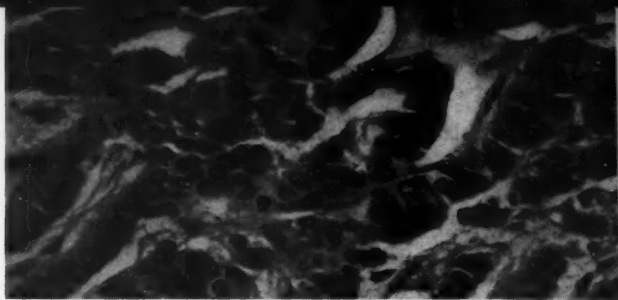


Figure 2

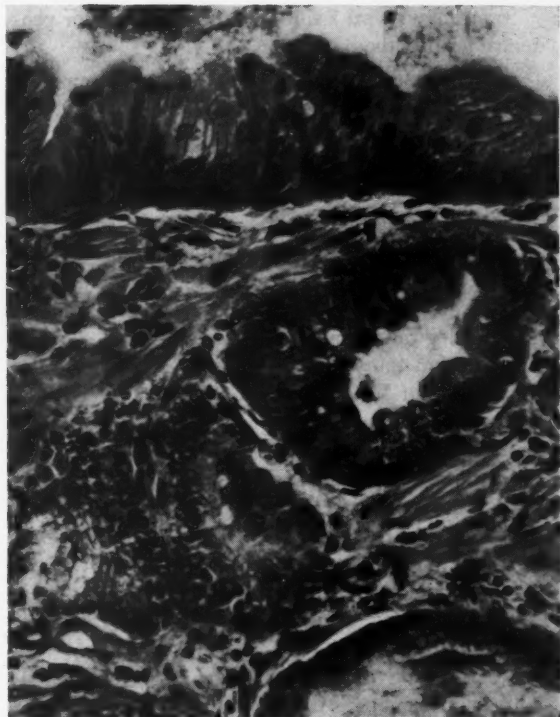


Figure 3

Fig. 1—Gastrointestinal series prior to surgical explorations.

Fig. 2—Section from tumor of right breast. Scirrhous carcinoma of breast. The pattern is a highly infiltrative one.

Fig. 3—Section from papilla of Vater. The tumor extends into the submucosa and muscularis. This extension is the only sign of malignancy because the cytology of the tumor is a benign type. The acini are large and vary in size and shape, being regular. There is no evidence of cellular infiltration in the manner of malignancy. The small amount of duodenal mucosa appears normal.

Fig. 4—X-ray of the abdomen showing the rubber catheter in position.

Fig. 5—Gastrointestinal series showing the gall bladder partially filled with barium.

Two laboratory procedures that may give valuable data are determinations for occult blood in stools and analysis of duodenal contents (Cooper & Silver). The second procedure is primarily valuable for a diagnosis of carcinoma of the ampulla rather than a benign tumor.

X-ray studies are helpful. If there is increased pressure on the bile ducts, cholecystograms will reveal a poorly functioning or non-functioning gallbladder. Barium studies of the gastrointestinal tract may reveal a filling defect if the tumor protrudes into the duodenum. (5)

The association of calculi, which is common, is probably secondary and due to biliary stasis.

Palpation is of little help in making the operative diagnosis because of the small size of these tumors. The best way of approaching them is transduodenal exploration.

Since this is a benign lesion, a conservative resection is advised in most cases, leaving the more radical procedures for cases in which the initial pathological diagnosis is carcinoma.

Benign tumors of the distal common duct and ampulla of Vater which do not protrude into the duodenum may require removal by a pancreaticoduodenal resection. A more conservative, short-circuiting operation, such as a cholecystoduodenostomy, will relieve the obstructive symptoms but will not prevent further development of the tumor. (6)

Cattell and Pyrttek (2) have suggested that in this area malignant changes may develop in a benign lesion.

Resection of the papilla for the treatment of benign tumors is usually curative. Papillectomy was first described by Halsted in 1898. When the tumor is protruding into the duodenum it may be locally excised by means of a transduodenal approach. Traction is placed upon the tumor to expose its base, and all tumor tissue is removed. It is important that no tumor tissue remains. If the tumor has a long pedicle, complete removal is facilitated.

After complete removal of the tumor, which usually includes the papilla of Vater and distal common duct, the common duct should be sutured to the posterior wall of the duodenum. If the pancreatic duct is transected, it should also be sutured to the duodenum. The common bile duct

is usually drained with a T-tube if it has been explored in its suprapancreatic portion.

#### PATIENT REPORT

A. S., a 58-year-old Negro woman, was admitted to St. Joseph's Hospital on August 13, 1959, under the medical service, with the admission diagnosis of infectious hepatitis. The patient's chief complaints were fever, pain in the epigastric and right hypochondriac regions, and marked jaundice. The symptoms started with nausea and vomiting after a heavy meal, approximately seven weeks prior to admission. A few hours after the onset, the patient developed epigastric pain. During the following days she was nauseated and noticed that her sclerae were becoming yellow in color and her urine had the appearance of concentrated tea.

Her father had died from heart disease, and one sister has diabetes mellitus. In 1944 the patient had a subtotal hysterectomy, a bilateral salpingo-oophorectomy, and an appendectomy because of fibromas of the uterus.

On physical examination, marked jaundice was noted in the sclerae, and the liver was palpable four finger-breadths below the right costal margin. A small firm nodule, 2 centimeters in diameter, was found in the lower lateral quadrant of the right breast. The patient's general appearance, in spite of the severe jaundice, was good; she was alert and cooperative, had lost little weight and was only slightly anorexic.

Laboratory findings on admission were: hemoglobin, 10.6 grams and hematocrit, 34 cc; urine, markedly choluric and strongly positive for bilirubin, but negative for urobilinogen; sedimentation rate was elevated, corrected sedimentation rate was 38 millimeters per hour; nothing remarkable was found in the white blood cell count and differential; total bilirubin, 15.3; serum proteins were within normal limits with preservation of the A/G ratio; thymol turbidity, 2.3 units; alkaline phosphatase, normal, being 1.3 units; prothrombin time, 16½ seconds, 48 per cent. Several stool cultures and preparations for parasites and ova, as well as blood cultures, were negative. A roentgenological examination of the chest, as well as flat and upright films of the abdomen, revealed no pathology. Gastrointestinal series revealed normal



esophagus and stomach. The duodenal bulb, particularly the second portion of the duodenum, appeared distorted to the roentgenologist. He could see no ulcer, but suggested the possibility of a small filling defect in the second portion of the duodenum. (Fig. 1)

Liver biopsy was productive of a mucoid greenish fluid, but no liver parenchyma was obtained. This fluid was examined, and a small amount of bile pigment and occasional pus cells were found. No neoplastic cells were seen, and the culture of this specimen showed growths of *Streptococcus faecalis*. The patient was later seen by the surgical service on August 23, 1959. The consultant's opinion was that this was an obstructive type of jaundice, and that the patient should be explored. The lesion in the right breast was examined and, with the retraction of the skin, appeared as a typical carcinoma of the breast. A tiny nodule was also palpable in the right axilla. On August 29, 1959, the patient was explored through a right paramedian incision. The liver was found to be enlarged and turgid. The gallbladder was enlarged and tense, but no stones were felt. The common bile duct was exposed and found dilated. No further pathology was found in the abdomen except that the absence of the uterus, tubes, ovaries and appendix was noted. The duodenum was mobilized by the Kocher maneuver, and the common bile duct was opened. Attempts to pass small catheters and probes through the ampulla failed so the duodenum was opened in its second portion. Previous palpation of the head of the pancreas revealed no pathology. On opening the duodenum, a small tumor arising from the ampulla of Vater was found. The tumor, 1.0 cm. in greatest diameter, was in the distal part of the papilla and apparently had occluded completely the lumen of the ampulla. The color of the tumor was darker than the color of the duodenum, and there was a clear demarcation between them. The tumor was grasped with forceps and an ellipse of mucosa around the tumor was removed along with the distal portion of the papilla of Vater. The pancreatic duct was not affected by this excision. The frozen section reported a benign tumor, and no further excision was considered necessary. A rubber catheter was passed through the common bile duct into the duodenum and left in place. The

common bile duct and the duodenum were repaired. Because of awareness of the inaccuracy of frozen sections and the question of whether or not this tumor might recur, a cholecystoduodenostomy was performed in the event of future obstruction of the common bile duct.

The serum bilirubin, three days after the operation was 6.1 mg per cent and 23 days after the operation was 2.4 mg per cent.

The permanent pathological report of the specimen of the ampulla of Vater was benign adenoma of the ampulla (fig. 3).

The patient made such good progress that a Halsted radical mastectomy with extensive axillary dissection and skin grafting was performed 11 days after the first operation. The pathological report showed scirrhous carcinoma of the breast with metastasis to the axillary lymph nodes (fig. 2). The patient was discharged four weeks after the first operation (October, 1959) in good general condition. She continued to gain weight and remained symptom-free. Post-mastectomy x-ray therapy is being administered at the time of the writing of this paper.

The patient was readmitted on January 6, 1960 for re-evaluation. She has had no symptoms relative to any of the previous two operations. Jaundice had disappeared completely and the sclerae were clear. She was eating a regular diet, having normal bowel movements, and was free of pain in the right upper quadrant. On physical examination, both incisions and the grafted site appeared well-healed. There was no evidence of recurrence or metastasis of the breast carcinoma. The laboratory findings were: Hemoglobin 85 per cent, 12.5 grams and the hematocrit 40 cc. The sedimentation rate was 13 millimeters per hour. The white blood cell count and differential count were normal. The patient had a normal cholesterol, normal serum protein of 7.6 mg. per cent with 4.6 mg. per cent albumin and 3 mg. per cent globulin with a normal A/G ration. The total bilirubin was 1.8 mg. per cent. The van den Bergh was negative. The thymol turbidity was 5.4 units. The alkaline phosphatase was 4.8 units. The cephalin flocculation test was negative. The bromsulphalein test showed a retention of only 10 per cent after 45 minutes. The serum amylase was 116 units.

On intravenous cholangiogram, the presence of a rubber catheter extending from the hepatic duct to the third portion of the duodenum was noted. Some air was found in the biliary tree (fig. 4). Gastrointestinal series showed nothing abnormal except a pouch connected with the duodenal bulb which corresponded to the cholecystoduodenostomy (fig. 5). Roentgenographic survey of the bones showed no evidence of metastasis. The patient was discharged three days after admission in excellent general condition.

#### COMMENTS

This patient was admitted with marked jaundice; however, liver function tests were inconclusive, making it difficult to determine whether this was an obstructive or parenchymal type of jaundice. The clinical findings did not suggest a tumor of the ampulla of Vater as a diagnosis. This was reached only after surgical exploration.

In this particular patient, the tumor was located at the most distal portion of the papilla. It was rather small and had grown into the duodenal lumen. The possibility of radical pancreaticoduodenectomy was considered, but the presence of a carcinoma of the breast partly influenced our decision to perform a local excision.

Excision of the tumor was performed, resecting an ellipse of duodenal mucosa several milli-

meters around the tumor. The distal ends of the common bile duct and pancreatic duct were not transected, therefore obviating anastomosis. Since the common bile duct was opened, the use of a long limb T-tube was considered initially, but was omitted in favor of a cholecystoduodenostomy, which, it was felt, would be more permanent and would better prevent recurrence of jaundice.

This case is of interest because of the presence of a concomitant carcinoma of the breast, which was treated by radical excision 11 days after the first operation, followed by radiation therapy. Studies on the patient's second admission revealed both sources of biliary drainage to be functioning. The patient was asymptomatic, and the presence of air in the biliary system did not interfere with normal function.

The diagnosis was confusing because of the difficulty in differentiating the type of jaundice involved. The absence of occult blood in stools also detracted from the diagnosis of a neoplastic process in the region of the ampulla.

Since a number of clinicians treat adenomas in this region by local excision and considering that this patient had a carcinoma of the breast, we feel that our method of treatment of the adenoma was adequate.

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## THIRD ANNUAL CARDIAC SYMPOSIUM of the HEART ASSOCIATION OF NORTHERN VIRGINIA, INC.

April 20, 1960—TERRACE ROOM

Arlington Towers, Washington Building, Arlington, Va.  
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# EMPHYSEMA

## FOLLOWING

### PNEUMONECTOMY

#### conservative treatment by sterilization

**P**LEURAL EMPHYSEMA after pneumonectomy, with or without bronchopleural fistula, may occur early or late in the postoperative period. This complication appears to be less common since the introduction and use of antibiotics intrapleurally and systemically.(1) There is a definite distinction between empyema occurring in patients upon whom pneumonectomy has been performed and those having resections involving less than the entire lung. The reason for the difference is the beneficial influence of the remaining lung tissue that can aid in filling the pleural cavity, since obliteration of the dead space is of primary importance in the prevention and elimination of infection in the pleural cavity.

There is discussion as to whether or not a bronchopleural fistula is the cause of infection of the pleural space. Some authors are of the opinion that the contamination of the pleural cavity is always associated with a leak in the bronchial stump; whereas others believe that a bronchopleural fistula is the result of infection of the pleural cavity. Kent(2) reported, "Either sequence of events may take place and that as a rule a bronchial fistula, which occurs within the first ten days after operation, is a true failure of healing in the bronchial stump and that the associated empyema is of secondary origin. On the other hand, in those instances of a later leak in the bronchus, usually from three to five weeks after

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and  
Otto C. Brantigan, M.D.

pneumonectomy, the cause is most commonly infection in the pleural cavity with an empyema which escapes through the originally healed bronchus." In these days of antibiotics an empyema is often essentially silent. In the case of a bronchopleural fistula, the question of active disease or infection at the site of division of the bronchus is an important factor. The presence of a fistula is suspected when the patient has empyema, expectorates bloody fluid, or develops a gradually increasing amount of subcutaneous emphysema. Where bronchial breakdown occurs after pneumonectomy, closed pleural drainage may be a life-saving procedure. After closed drainage has been instituted, it is important to instill an antiseptic solution or an antibiotic agent that is best suited for the type of bacteria present. It is also desirable to use an agent that will tend to seal over the air leak and not cause further breakdown of the bronchial stump. When the entire lung has not been removed, the problem of a bronchopleural fistula is entirely different and definitely more amenable to treatment.(3) After

*A conservative method of treatment for empyema following pneumonectomy has been described. It has been used successfully since 1943. The last patient was treated in 1959.*

total pneumonectomy has been performed there is no lung tissue available to obliterate the pleural cavity in combating infection of that space. For this reason, a thoracoplasty is preferable in some instances. Such authors as Burnett, Rosemond, Hall, Caswell, Lockwood, White, and Murphy, and Hirschfeld, Boggs, Abbott, and Pilling have described promising results in the treatment of empyema by the use of antibiotics without open surgical drainage.(2, 4) It was the experience of Kent(2) that such a plan of conservative management is effective if the empyema is not too virulent, if treatment is begun early in the course of the disease and there is no loculation, if the pus is not too thick, and if adequate aggressive therapy is applied throughout the treatment.

The first step of treatment is adequate drainage. Definitive treatment is carried out by one of two methods: obliteration of the pleural space by multiple stage thoracoplasty after open drainage, or sterilization of the pleural space. If there is a bronchopleural fistula, closed drainage with irrigation and instillation of antibiotic drugs must be used with caution since these solutions may be aspirated through the fistula. If the bronchopleural fistula does not close after a few days' trial by the sterilization method, treatment by multiple stage thoracoplasty becomes necessary, usually after a period of open drainage of the pleural cavity. The second sterilization method of the pleural space is by far more comfortable for the patient. In the event treatment by sterilization is not successful within a few days, treatment by open drainage and thoracoplasty can be used. After closed tube drainage of the pleural space, sterilization of the pleural space is accomplished by the use of several drugs. The antibiotic to which the bacteria are sensitive, Streptokinase and Streptodornase as a fibrinolytic agent, and sodium tetradecyl sulfate 1:500 in azochloramid 1:3300(3, 5, 6) as a nonspecific antiseptic and irrigating agent.

Closed tube drainage of the pleural cavity is used instead of repeated needle aspiration and instillation because it is easy to initiate, simple, efficient, and less bothersome to the patient and to the doctor. Open thoracotomy drainage is not employed because the pleural space cannot be sterilized if exposed to outside influences. The site of introduction of the tube is determined by locating the exudate with an aspirating needle. In

cases in which the empyema is large, the best site of introduction of the tube is the eighth interspace at the midaxillary line; however, it can be placed in any location where the pus is found. Local anesthesia is used. A small incision is made in the skin, and a trocar and cannula are thrust into the pus in the pleural cavity. The trocar is removed, and a straight catheter, 16 or 18 F., is inserted through the cannula; the cannula is then removed. The intrapleural tube is anchored with adhesive tape, then connected to a Y tube, with one limb leading to a trap bottle (underwater seal). The other limb of the Y connector is connected to an overhanging bottle containing the solution of sodium tetradecyl sulfate 1:500 in azochloramid 1:3300. Irrigation, drainage, instillation of antibiotics, and Streptokinase are regulated according to a rigid, fixed schedule. Absolute aseptic technique is used throughout the treatment. The schedule is divided into four-hour periods as follows:

A. *First four hours.* The drainage tube is clamped off. Azochloramid-sodium tetradecyl sulfate solution is instilled into the pleural cavity, the quantity depending on the size of the pleural space or the presence of a bronchopleural fistula, but often using 200-400 cc., Streptokinase 100,000 units with Streptodornase. The appropriate antibiotic in maximum dosage is instilled into the pleural cavity by injection into the chest tube. These solutions are allowed to remain in the pleural cavity for four hours.

B. *Second four hours.* The clamp on the pleural drainage tube is removed. Drainage is by gravity.

C. *Third four hours.* The drainage tube is clamped off. Azochloramid-sodium tetradecyl sulfate solution is instilled into the pleural cavity in same quantity as is used in A.

D. *Fourth four hours.* The clamp is removed from the pleural drainage tube, and drainage is accomplished by gravity. A culture of the pleural space is obtained.

The schedule is then repeated as many times as may be necessary. The appropriate antibiotic is administered by the oral or parenteral method for the systemic effect. When five consecutive cultures show no bacterial growth (or proves



sterile) and there is evidence of closure of the bronchopleural fistula, if one were present at the start, the intrapleural drainage tube is removed. The skin opening is closed by pulling tight a suture placed for this purpose when the tube is inserted.

After removal of the intrapleural drainage tube, aspiration of the pleural cavity and instillation of azochloramid-sodium tetracycl sulfate solution and the proper antibiotic are carried out on three successive days by the use of a needle and syringe; the Streptokinase and Streptodornase solution is no longer used. Cultures are taken each time the chest is aspirated. If the cultures prove sterile, the interval between aspiration and instillation is lengthened gradually, every other day for two treatments, two times a week for two weeks, once a week for four weeks, and finally once every three months for two treatments. If at any time a positive culture is obtained, the entire method of treatment should be abandoned or reconsidered. Rigid asepsis must be maintained throughout treatment. The systemic antibiotic drug is usually discontinued after seven to ten days.

#### CASE REPORT

M. B., a 24-year-old Negro female, was admitted to St. Joseph's Hospital on July 26, 1959. Six days prior to admission, the patient complained of headaches, general malaise, and low grade fever; two days prior to admission, she started coughing up bright red blood. The fever increased when she began to complain of pain in the lower half of the left hemithorax. The initial diagnosis was pneumonia.

Roentgenographic findings revealed heavy infiltration of the entire left lung which obscured all details, with numerous highlights suggesting cavitation. The mediastinum was retracted to the left. The right lung was clear.

She was treated with large doses of antibiotics and supportive measures. Her temperature decreased on the first day and her condition improved clinically; however, the radiological appearance of the chest did not change. After consideration of the good general condition of the patient after ten days in the hospital, a bronchogram was done, which showed definite tubular and saccular bronchiectasis of the entire left lung

with atelectasis. A pulmonary resection was advised.

Pneumonectomy was performed on August 18, 1959, 24 days after admission. This procedure was particularly difficult because of dense adhesions of the visceral and parietal pleura. The main bronchus was closed without difficulty. The pleural cavity was irrigated with saline solution and closed without drainage. On the second postoperative day, the patient developed fever, which decreased on the seventh postoperative day. She received treatment with antibiotics and was afebrile and asymptomatic until the fifteenth postoperative day, when she was discharged from the hospital.

A week after discharge, the patient again complained of chest pain and developed fever. A small opening on the medial portion of the wound started to exude fluid, and she was readmitted two weeks after her discharge from the hospital. There was no evidence of a bronchopleural fistula. A closed thoracotomy was done and an 18 French catheter was inserted in the chest cavity in the anterior second interspace, slightly to the left of the midclavicular line. This catheter was connected to a Y-glass connector. One end was connected through a rubber tubing to an irrigating bottle; the other was connected to an underwater seal drainage bottle on the floor. The rigid schedule of treatment previously outlined was followed. Several cultures of the exudate obtained before this method was started revealed "intermediate coliform bacillus" which was sensitive to Chloromycetin®. Chloromycetin® in one gram doses was instilled into the pleural cavity and orally in doses of 500 mg. every six hours. The symptoms disappeared immediately after treatment was started. Three months after her second discharge from the hospital the patient was free of symptoms. All cultures have been sterile since the first treatment.

Eight patients have been treated by this method since December, 1943. With one exception, all have been cured, and there have been no recurrences of empyema. All patients have been followed since December, 1943. The fourth patient had a recurrence of empyema nine months after treatment was discontinued. Of the eight patients, pneumonectomy was done for carcinoma of the lung in five, for tuberculosis in one, and for bronchiectasis in two. Three of the eight patients

showed hemolytic staphylococcus aureus or albus by culture.

#### DISCUSSION

It is of first importance to observe a sterile technique in the treatment of the patient, consisting of thoracentesis, insertion of a chest catheter, and the alternating irrigation and instillation of the pleural cavity. It is also necessary to follow a fixed schedule for the instillation of the drugs and drainage of the pleural cavity.

Selection of the proper antibiotics should be determined by culture and sensitivity tests. Maximum doses of antibiotics should be used in the pleural space and systemically. The use of Streptokinase and Streptodornase apparently shortens the

time of treatment. Fever may complicate the use of Streptokinase and Streptodornase but does not contraindicate their use.

Cultures should be taken frequently; after the chest catheter is removed a culture should be taken each time the pleural space is aspirated. The patient should be observed closely and followed for at least six months after the treatment is discontinued, to be certain that there is no recurrence of the empyema.

The prolonged course of treatment is certainly justified in order to prevent recurrence of the infection. It is well known that bacteria may be dormant for long periods of time, however, if treatment is carried out as described, the final and complete sterilization seems assured.

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4309 Walther Boulevard  
Baltimore 14, Maryland  
(Dr. Zapata)

104 W. Madison Street  
Baltimore 1, Maryland  
(Dr. Brantigan)

### Pediatric Refresher Courses

Two short refresher courses will be given by the Children's Hospital of Philadelphia and the Graduate School of Medicine, University of Pennsylvania.

#### 1. PEDIATRIC ADVANCES. May 30 through June 3, 1960.

Conducted by the staff of The Children's Hospital of Philadelphia. The curriculum will consist of clinics, demonstrations and panel discussions in selected aspects of contemporary pediatrics in which important advances are being made.

#### 2. PRACTICAL PEDIATRIC HEMATOLOGY. June 6 through 10, 1960.

Conducted by Irving J. Wolman, M.D., Thomas R. Boggs, Jr., M.D., and other members of the Hematology Department of the Children's Hospital of Philadelphia.

The program on the last two days will be devoted to Problems of Blood Grouping, Neonatal Jaundice, Kernicterus and Exchange Transfusions. Physicians may register for these 2 days only if desired.

Inquiries should be addressed to Irving J. Wolman, M.D., director of postgraduate education, The Children's Hospital of Philadelphia, 1740 Bainbridge Street, Philadelphia 46, Pa.

## COMMITTEE FOR THE

# STUDY OF PELVIC CANCER

(Under the auspices of the Medical and Chirurgical Faculty and the Maryland Division of the American Cancer Society)

Beverley C. Compton, M.D.

Secretary

*The Committee for the Study of Pelvic Cancer meets monthly, October through May, for the discussion of selected cases. All physicians are cordially invited to attend these meetings.*

### *Abstracts of case discussions*

#### I

A 29-year-old white patient, married, gravida 6, was delivered August 2, 1959. She was under the care of her physician during pregnancy and at delivery. She gave a history of slight spotting about once a month during pregnancy and slight bleeding during the last month. After delivery she continued to have rather profuse, intermittent bleeding. She consulted her physician in late August and was given some medication which checked the bleeding for a few days, but the bleeding recurred, and she returned to her physician in late September. A pelvic examination was made and the cervix biopsied at this time. When the biopsy was reported positive, the patient was referred to the hospital clinic for treatment.

**Diagnosis:** Carcinoma of the cervix, international classification, stage I B.

**Treatment:** Radium and deep x-ray therapy.

**CHAIRMAN:** This patient was delivered August second, 1959. Do we have any information as to examination during pregnancy or whether the cervix was inspected at the time of delivery?

**COMMITTEE MEMBER:** I believe not. We have written to the physician but have not heard from him.

**CHAIRMAN:** We have some additional history from the hospital record. They note that the patient had had some intermenstrual bleeding since

the time of her previous delivery in May of 1958 and also slight post-coital bleeding. According to our record, the patient said she had no irregular bleeding before her most recent pregnancy. In any case the obstetrician had the opportunity to make the diagnosis and did not do it.

**COMMITTEE MEMBER:** What does the hospital record say as to the appearance of the cervix when the patient first came for treatment of the carcinoma?

**COMMITTEE MEMBER:** The lesion is described as  $4\frac{1}{2}$  centimeters in diameter and a gross lesion.

**COMMITTEE MEMBER:** Which means it was there during pregnancy.

**COMMITTEE MEMBER:** And the diagnosis could have been made. The patient says that she had some bleeding every month during pregnancy and increased bleeding during the last month. The cervix should have been inspected. Inspection, smear, and biopsy are far from being contraindicated in pregnancy.

**CHAIRMAN:** We teach that bleeding during the last trimester of pregnancy is due to placenta previa until proven otherwise. We avoid any extensive manipulation, but this does not contraindicate inspection or cytology. In this case, if the cervix had been visualized, it probably would have been biopsied—or should have been—and the diagnosis made.

**COMMITTEE MEMBER:** How about biopsying during pregnancy? Do you run into any trouble with bleeding?

**COMMITTEE MEMBER:** Not as much as you might think. I have not had any trouble.

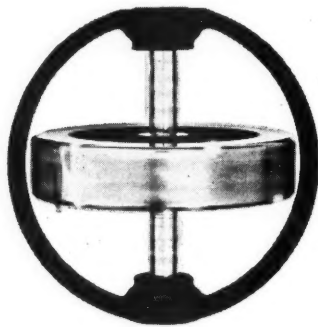
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of the patient's  
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Diacetate Parenteral (for intra-articular and intrasynovial injection). Vials of 5 cc. (25 mg./cc.).

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LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

HOUSE OFFICER: You may get a little more bleeding, but we have had no real difficulty.

CHAIRMAN: I think we are all agreed that the diagnosis could and should have been made during pregnancy.

## II

A 53-year-old Negro patient, married, gravida 5 0 0 5, gave a history of bleeding, four years postmenopausal, beginning in January 1959 and continuing intermittently. She said that she consulted a physician soon after the onset of symptoms and was given some medication, but a pelvic examination was not made. The bleeding stopped and she had no further difficulty until April when she had slight bleeding for one or two days. In May she had three episodes of moderately profuse bleeding. She returned to her physician in June, was examined and advised to go to the hospital.

*Diagnosis:* Carcinoma of the cervix, international classification, stage III.

*Treatment:* Cobalt therapy, followed by radium application.

CHAIRMAN: We have a letter from this physician giving the following information:

3/20/59: The patient was seen complaining of vaginal bleeding off and on for two months.

T. 98.6. P. 82. B.P. 210/100. Weight 145 lbs.

Pelvic: Slight uterine bleeding. Some suggestion of a mass.

The patient was advised to return in a week or two for further studies including cancer cytology smear. She failed to keep this appointment.

5/21/59: The patient complains of vaginal bleeding again. Some weight loss. She was advised to go to the hospital for a dilatation and curettage. She said she would think it over.

6/25/59: Patient returned for a note to take to the hospital.

You will notice that the stories as given by the doctor and by the patient do not entirely agree.

The doctor says a pelvic examination was made at the time the patient first consulted him; the patient says she was not examined but was given some medication.

COMMITTEE MEMBER: He missed the boat anyway. When a patient is having postmenopausal bleeding, you don't just ask her to come back in a couple of weeks. This is physician delay.

CHAIRMAN: Does anyone disagree with that?

COMMITTEE MEMBER: I don't see how you could call it anything else.

CHAIRMAN: We hear this story many times. The patient consults a physician because of vaginal bleeding, and an adequate pelvic examination is not made or the patient is asked to return for examination when the bleeding stops. Obviously if told to return when the bleeding stops, some patients will never get back. The doctor who first sees these patients has the opportunity to make the diagnosis. If this opportunity is missed there may be long delay and considerable progress of the disease before the patients get to treatment. If the physician is too busy or feels incapable of taking a biopsy or of making any adequate pelvic examination, it is his responsibility to refer the patient for examination.

## III

A 34-year-old white patient, married gravida 6, was referred to the gynecological clinic in September, 1955, following a six-weeks postpartum examination regarding chronic cervicitis. She had a history of some spotting during pregnancy, but this was thought to be due to cervicitis. A biopsy in the obstetrical clinic had been reported as showing basal cell hyperactivity. A repeat biopsy in the gynecological clinic on October 1 was reported as chronic cervicitis with epidermidization. The patient was advised to return as necessary and was not followed further. She was next seen in this clinic in June, 1959, when she came in because of urinary symptoms. She had had two pregnancies in the interim—delivered at other hospitals. She gave a history of profuse periods during the past year and occasional

postcoital bleeding. The last menstrual period was April 20, 1959, and she was thought to be in early pregnancy. A cervical biopsy on June 29 showed intraepithelial carcinoma. A conization on July 19, showed early stromal invasion.

**Diagnosis:** Carcinoma, cervix, international classification, stage I A, with pregnancy about 12 weeks.

**Treatment:** Modified Wertheim hysterectomy.

**CHAIRMAN:** I have reviewed the slides from 1955 and found them most interesting. I feel that the first one, from the biopsy taken in the obstetrical clinic, shows some intraepithelial carcinoma; the second one shows one area that is suspicious. Of course, I am using a retro-spectroscope as well as a microscope, and that is a helpful instrument. Whether or not today we would have made a definite diagnosis of intraepithelial carcinoma may be open to question. It was still a very early case when the patient came to treatment in 1959. It was almost a stage zero.

**COMMITTEE MEMBER:** I have not seen the 1955 slides but have seen the slides from 1959. I feel there is definite invasion, but early. I am sure there would be those who would argue as to whether this is invasive or intraepithelial.

**CHAIRMAN:** In classifying these cases, we classify loss of time of more than one month as delay. There is the question whether this diagnosis could have been made in 1955. In retrospect, I feel sure intraepithelial carcinoma was there in 1955; apparently in 1959 there was very early invasion.

**COMMITTEE MEMBER:** I do not see much in this case to criticize.

**COMMITTEE MEMBER:** I think there is one thing open to question and that is the follow-up. With basal cell hyperactivity, should not the patient have been asked to return for at least a smear?

**COMMITTEE MEMBER:** In the interim between 1955 and 1959, the patient had two pregnancies. It would be interesting to know if any Papanicolaou smears were taken during that time. Do we know that?

**SECRETARY:** The hospital record for the pregnancy in 1957 was checked, and there was no record of a smear. Apparently there was nothing abnormal during pregnancy or at delivery. The record for the pregnancy in 1958 has not been available.

**CHAIRMAN:** I think we are getting down to a fine point when we criticize whether or not a patient was followed because of one report of basal cell hyperactivity. At our hospital we do have a so-called "basal cell hyperactivity clinic" and do follow these patients. I do not know for what reason this patient was not followed. If the slides were read in 1955 as I read them today, she would have been followed. We do know that a certain per cent of cases showing basal cell hyperactivity do develop into intraepithelial carcinoma and some into invasive carcinoma. Dr. Gerald Galvin and others who have done considerable work on this feel that the greater the degree of basal cell hyperactivity, the higher the per cent of intraepithelial carcinoma later.

**COMMITTEE MEMBER:** I would like to ask one question. In these patients with chronic cervicitis, diagnosed as having basal cell hyperactivity to a greater or lesser degree, what do you do at that stage of the game, if anything?

**CHAIRMAN:** Watch them carefully.

**COMMITTEE MEMBER:** You would not cauterize the cervix?

**CHAIRMAN:** That would depend on the symptoms and what you could see on the cervix.

**COMMITTEE MEMBER:** There is usually some kind of a lesion if there was enough reason to do a biopsy.

**CHAIRMAN:** I would do a biopsy before cauterizing any lesion. If there were enough troublesome symptoms—if a woman had a profuse leukorrhea—I would cauterize the cervix.

**COMMITTEE MEMBER:** The point I am trying to make is that the thing that led to a biopsy in the first place needs some kind of treatment besides "watch."

COMMITTEE MEMBER: But suppose a positive smear led to the biopsy; what then?

CHAIRMAN: If it was a routine Papanicolaou smear, reported as class III, and the biopsy showed basal cell hyperactivity, I would watch only. Here I am assuming that the patient is asymptomatic. If symptoms indicated, basal cell hyperactivity would not deter me from doing a cauterization.

COMMITTEE MEMBER: What would you do if the patient had no symptoms and a normal appearing cervix and a class III smear?

COMMITTEE MEMBER: I would certainly do repeat smears and a biopsy and then follow her until I knew she was all right.

COMMITTEE MEMBER: I think if you treat a patient on the basis of basal cell hyperactivity alone, you do a lot of unnecessary treatment.


COMMITTEE MEMBER: I agree; but if you biopsy for less than a clinically important lesion, I want to know what treatment is indicated. Possibly there is no real lesion, but the cervix does not look truly normal. I want a "rule to live by."

CHAIRMAN: If the patient has no symptoms, follow with smears; if the smears give indication for a biopsy, take a big biopsy and take several bites. Sometimes I do a biopsy that is almost a cone.

To get back to the case we were discussing, how do you think it should be classified?

COMMITTEE VOTE: No delay.

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## SUMMARY

Total cases to January 15, 1960 ..... 1977

### Classification:

No delay .....	684
Asymptomatic detected cases ...	63
Patient delay .....	805
Physician delay .....	147
Physician and patient delay ....	130
Institutional delay .....	48
Institutional and patient delay ....	47
Institutional and physician delay ...	10
Institution, physician, and patient delay .....	4
Inadequate or improper treatment .	21
Delay due to laboratory error ...	7
Unclassified to date .....	11



## COMPONENT MEDICAL SOCIETIES



### ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

*Journal Representative*



THE LIBRARY COMMITTEE

Left to right: Drs. Leslie E. Daugherty, Calvin Y. Hadidian, and Abraham J. Mirkin, chairman.

### Memorial Hospital Library Cumberland, Md.

CONCENTRATING ON monographs and current journals, the Memorial Hospital library extends its usefulness to every physician using the hospital. Lately modernized in its physical structure, the library now contains a fairly large number of the latest editions in medicine and surgery and the specialties. It is augmented by gifts of books by members of the visiting staff and it now has an organized program of replacements and a purchasing schedule which should make it one of the outstanding hospital libraries in Maryland.

Organized in 1950, the library's first chairman was Leslie E. Daugherty, M.D. The present Library Committee is composed of Drs. Abraham J. Mirkin, chairman, Calvin Y. Hadidian, and Leslie E. Daugherty.

### Executive Committee Meets With Health Officer

CARLTON BRINSFIELD, M.D., Thomas F. Lewis, M.D., Martin Rothstein, M.D., Leslie E. Daugherty, M.D., and Leland Ransom, M.D. members of the executive board to the Alleghany-Garrett County Medical Society, met with Dr. Ton von Strien, Alleghany County Health Officer, in an effort to establish a policy on polio immunization of school children. The committee concurred in a proposal to discontinue the giving of polio shots in the public schools. Those who hold health cards and are indigent or medically indigent will be vaccinated in the clinic of the Public Health Department, and an effort will be made to get all others to go to their family physician.

It was noted that 87 per cent of the children of the county were given the protection of polio vaccine in the past year. All children in the county were offered this protection and 96.8 per cent of all children entering the first grade were thus immunized.

### The Forand Bill

**T**HE CUMBERLAND Chamber of Commerce went on record as opposing the Forand Bill, giving the following reasons:

1. Financing of hospital services, nursing home services, and surgical services to those eligible for OASI would extend far beyond the original intent of Social Security by extending services which are not comparable between one community and another.
2. This legislation would apply only to a certain percentage of our people.
3. It would cost far more to administer on a federal level than it would at the local level.
4. The cost of financing the services would expand beyond anything we now contemplate, thereby driving the cost of OASI far beyond the 9 per cent limit now established. As in the case of any "free service," many people will use it for questionable needs, resulting in further overcrowding of hospital facilities and creating a demand for expansion which would cause financial hardship on local government and taxpayers.
5. It would be another step in socialization, pre-empting local responsibility by the federal government.
6. A vast number of private insurance plans are available, so there is no reason for the government to go further into the insurance business.

### United Fund Makes Offer

**T**HE COUNTY UNITED has made a gift offer of \$20,205 to the Allegany-Garrett County Heart Association to cover its annual budget for 1960 providing that the Association would not conduct a public campaign for funds. A similar

offer for \$22,000 was made to the Allegany Chapter of the American Cancer Society.

### Personals

**D**R. EARL PAUL, Cumberland, was guest speaker at the February meeting of the Sacred Heart Hospital Nurses' Alumnae Association. His topic was "Terminal Aortic Aneurisms and Peripheral Arterial Occlusive Disease."

At a recent meeting of the Western Maryland-Memorial Hospital Alumnae, Dr. L. Michael Glick, Cumberland, spoke on "Diabetes Mellitus."

The Cumberland Flying Association, of which W. Royce Hodges, M.D., is a member, met and discussed plans for a cross-country flight in the latter part of May. Prizes will be awarded for precision flying based on aircraft manufacturers specifications.

Dr. Wyand F. Doerner spoke on the "Common Arrhythmias of the Heart, Etiology, Clinical Findings and Management" at the Cumberland Memorial Hospital's monthly medical-surgical chest disease conference.

A Garrett County woman, snowbound in her home near Avilton, recently gave birth to a baby daughter. Delivery was aided by Dr. Martin Rothstein, of Frostburg, who gave instructions to the woman's family over telephone.

Drs. L. Michael and Gina M. Glick, Cumberland, announced the birth of a son, Mark Michael, on January 30.

A daughter, Susan, was born February 9 to Dr. and Mrs. James T. Johnson, Jr., of Cumberland.

Thomas W. Cawley, father of Dr. Frank T. Cawley, Cumberland roentgenologist, died January 28. The deceased had resided with his son for the past 10 years.

*The better part of one's life, consists of his friendships—Abraham Lincoln*

## ANNE ARUNDEL COUNTY MEDICAL SOCIETY

**T**HE ANNE ARUNDEL County Medical Society held its regular meeting on January 20, 1960, at Carvel Hall, Annapolis. A film dealing with medical practice in Africa was shown.

**Dr. Walter Landmesser was accepted as a transfer member from the Baltimore City Medical Society.**

Election of officers was held, and the following were duly elected for the forthcoming year:

*President:* R. McLaughlin, M.D.

**Samuel Borssuck, M.D.**

*Journal Representative*

*Vice president:* F. Shipley, M.D.

*Secretary:* Wm. Thomas, Jr., M.D.

*Delegates:* F. Hawkins, M.D., J. Lyons, M.D., M. Alden, M.D.

*Alternate delegates:* R. Riley, M.D., J. Wilkens, M.D., R. Hahn, M.D.

*Delegate to Planning Committee:* M. Waite, M.D.

*Alternate:* R. Peeler, M.D.

*Journal Representative:* S. Borssuck, M.D.

*Board of Censors:* F. Codd, M.D., J. R. Martin, M.D., J. Sheehan, M.D.

## BALTIMORE CITY MEDICAL SOCIETY

**CONRAD ACTON, M.D.**

*Journal Representative*



**A**LFRED BLALOCK, M.D., moderator, and his panel convinced the audience at the February 5 meeting of the Baltimore City Medical Society that cardiac surgery has come of age. Departing temporarily from their special and unique methods of heart surgery, the speakers in turn synoptically presented (a) the background, (b) the diagnosis, (c) the decision, and (d) the post-operative factors of major importance in achieving the maturity of this specialty within a specialty.

**R. Adams Cowley, M.D.,** professor of thoracic surgery at the University of Maryland, elaborated on the background and preparations necessary for successful cardiac surgery, commenting wryly on the large number of doctors necessary in staffing cardiac surgery for a single operation.

**Leonard Scherlis, M.D.,** associate professor of medicine at the University of Maryland,

detailed those aspects of diagnostic exactness necessary to the success of cardiac operations. "So far no exploratory cardiomyotomies are done," he said, "and the diagnosis must be exact and accurate." Newer techniques of cardiac diagnosis have been developed for this purpose. No part of the body—not even the heart—is sacred from the exploratory needle any more. The technique of transcardiac radiography, in which the exploring needle perforated the auricular septum, was graphically illustrated.

**Richard Ross, M.D.,** assistant professor of medicine at Johns Hopkins Hospital, assuming the diagnosis has been determined exactly, enumerated the factors which the physician must consider in deciding whether or not to operate. The indications for operating and the basic principles guiding judgment were briefly touched on. Whether the lesion is correctible (that is, either obstructive or communicating); whether essential structures

are present to enable repair; and whether the disability of the individual is due to the heart lesion are factors to be weighed.

Henry D. Bahnson, M.D., assistant professor of surgery at Johns Hopkins Hospital, spoke about special problems of the recovery phase after surgery. Heparin is difficult to neutralize; emboli and thrombi form and arrhythmias develop.

Questioned about future development, the panelists expressed divergent expectations. Cinefluorography, coming into use as part of the exact diagnosis, should offer a great deal of help, as will methods of making surgery easier by quieting the heart. One participant disclosed that his favorite "quieter" is intermittent clamping of the aorta to produce anoxic cardiac arrest. Myocardial perfusion through the coronaries has been done for better viability in open heart surgery. Discussion of cardiac problems in a question and answer period, led by Moderator Blalock, was spirited.

Approximately half the audience remained for the business session which followed. These hard-core members were introduced to the parliamentarian, Mr. William Evans, who came well recommended and assisted in the smooth running of the meeting.

Dr. Leonard Scherlis announced that a home-care program of the American Heart Association was being implemented in Baltimore as a pilot study in cost evaluation with an eye toward a nationwide program in the future.

Dr. Raymond V. Rangle's resolution, with wording now approved by members of the Committee meeting with the Faculty Committee on Liaison, was reintroduced. Somewhat abbreviated, the resolution was read by Dr. J. W. Ashworth, chairman of the Committee, and substituted for the original resolution, it was moved and passed.

Samuel Morrison, M.D., presented a

brief paper, more in the nature of an editorial, on patient care in small hospitals. He mentioned the vigorous meeting of the City Society in November as seemingly "anarchy" and urged everyone to unite in support of the small hospitals lest separated we fall.

Newland Day, M.D., chairman of the Legislative Committee, read the significant facts about the Forand Bill; whereupon a resolution opposing its features was passed unanimously, to be forwarded to our senators and representatives in Congress. Dr. Day also reported that a bill in City Council, allocating radiation hazard control to the purview of the Commissioner of Health, had just in the past day been brought to the attention of his committee, and they had not had sufficient time to analyze it. A motion was made that the City Council be requested to defer action until the City Society's committee has had a chance to study the bill. Huntington Williams, M.D., commissioner of health, was asked by President Diggs for pertinent information. Dr. Williams again proved himself to be a spellbinder. He called attention to the fact that 18 other states have similar laws and that this is a "model law" which conforms to the state's legislation. He added that inadvertently the proposed enactment was brought only to the attention of the State Medical Society and the City Society was bypassed through oversight. He advised that Sheldon Eastland, M.D., chairman of the Faculty's committee, was prepared to report favorably on behalf of the State Society at the City Council hearing. With this background information, the members of the Society reversed their field and voted unanimously to support the bill assigning control of radiation hazards to the Baltimore City Commissioner of Health.

Raymond V. Rangle, M.D., inquired whether visitors were permitted at meetings of the Executive Board and was told that they were welcome; however, there were some matters discussed that were not suitable for general dissemination, and visitors would be asked to leave when such matters arose.



William D. Lynn, M.D., rose to protest about the insurance that had been offered to the members and proposed that a committee be appointed to investigate the selection and designation of insurance for the City Society members. The motion was carried, and a committee would be appointed to report at the next meeting.

\* \* \*

**T**HE EXECUTIVE BOARD meeting on Tuesday, February 9, 1960, covered approximately 17 items in its three-hour session. One of the principal interests was the question posed by the City representatives to the Faculty Planning Committee concerning the desirability of organizing statewide specialty sections. In the early days of the Faculty, specialists were located only in the city; hence statewide specialty groups were not considered. Today, however, specialists in the counties are interested in the programs of the City Society's specialty sections. Of 14 specialty organizations, only two are statewide; the other 12 are represented in City sections. Of the latter 12, seven specialties have a corresponding statewide group not sponsored by the Faculty. Since county physicians are not eligible for full membership in the City Society, the question has been put to the Faculty's Planning Committee whether the Faculty should embark on a specialty section organization of its own to fill the growing need. If organized, what should be the relationship of Faculty sections to the existing City sections? Would the City sections prefer to remain independent or to merge with the higher echelon State groups, since a large part of the membership would be essentially the same in each? The Executive Board could not take a definite stand without consulting the various sections concerned. The general sentiment was, "Live and let live"; if the component county societies want to organize within the framework of the Faculty specialty sections for advancement in specialty integration through national bodies, they should be encouraged. If the specialty sections of the City Society later feel they have become superfluous, that Faculty sections have supplanted them, the Executive Board would then see no reasons why the City sections should not be merged.

An opinion from our legal counselor,

Mr. G. C. A. Anderson, revealed that some circulars put out by casualty insurance carriers directing their insured to go to certain doctors were in direct violation of the Medical Practice Act and its specifications on advertising. The secretary was directed to remind the membership of the stringent requirements in this regard.

W. Frank Cox, M.D., chairman of the Committee on Emergency Medical Calls, gave the report of his committee's activities for the past year. This had not been taken up at the business meeting in the detail which the Board felt was proper. Dr. Cox was asked to sum up the facts and he and his committee were congratulated for their splendid work and the effect it has had on public relations. He presented the problem of uneven distribution of physicians and the misunderstandings that occasionally arise regarding the emergency medical call setup, making it clear that all emergency patients who say they are *not* able to pay for a physician are to be taken by municipal ambulance to the nearest hospital accident room. Those who say they can and will pay for care are referred to physicians. Emergency medical calls are not necessarily charity work, he pointed out, and younger physicians who take part are vigorous people who are stimulated by the variety of professional problems directed to them. It is hoped that new physicians starting in practice and physicians living in areas of minimal physician saturation will assist on the panel for periods of time convenient to them. Members were urged to let the committee know if they would accept calls on the important holidays, such as the Fourth of July and Labor Day, when many physicians are away. These are the most critical periods to help with this important aspect of the Society. It was favorably noted that even during the current "flu" epidemic, with the tremendous increase of calls due to respiratory illnesses, the system worked well and without breakdown.

The parliamentarian, at the last meeting, had called attention to the fact that no specification for a quorum was spelled

out in the bylaws. This problem was referred to the Committee on Constitution and Bylaws for remedial action.

The budget was reviewed and Dr. Fisher's estimates of expenses were approved.

As a result of the newspaper statement made by State Auditor, Mr. Leo

Parr, that he lacked medical and pharmaceutical help in his audit of the Baltimore City Medical Care Program, President Diggs reported that he had volunteered in the name of the Society to help Mr. Parr. The latter had courteously replied that his Audit was completed and that he could not take advantage of the offer.



## BALTIMORE COUNTY MEDICAL ASSOCIATION

WILLIAM H. F. WARTHEN, M.D.

*Journal Representative*

THE BALTIMORE COUNTY Medical Association met at luncheon at the Rosewood Training School, Owings Mills, on January 20, 1960. Dr. Reese reported that he had officially submitted for the 1960 elections the name of Charles F. O'Donnell, M.D., as a nominee for president of the Medical and Chirurgical Faculty and the name of William A. Pillsbury, M.D., for membership on the Council of the Faculty.

The contract presented by Mr. Robert T. Strudwick, representative of the Northwestern Insurance Company, was discussed, and Dr. Rehberger advised that the contract did not limit solicitation to direct mail, as had been originally stipulated and later adopted by the members of the Association. It was moved by Dr. Strobel, seconded by Dr. Pillsbury, and unanimously carried that before being signed by the officers of the Association, the contract be returned for addition of a

clause stating that solicitation would be by direct mail rather than personal office solicitation.

Dr. Reese read a letter from Perry F. Prather, M.D., director of the Maryland State Department of Health, requesting accuracy and legibility on the part of physicians in entering the required data on death certificates.

Morton J. Ellin, M.D., was voted into active membership, and the transfer of Emidio Bianco, M.D., from the Baltimore City Medical Society was approved.

Harry G. Butler, M.D., of the staff of the Rosewood Training School, introduced the speaker, David S. Alexander, M.D., fellow in pediatrics at The Johns Hopkins Hospital. Dr. Alexander's topic was "Chromosome Studies in Mongoloids."

## AMERICAN UROLOGICAL ASSOCIATION, INC.

May 16-19, 1960

Palmer House, Chicago, Illinois

## CHARLES COUNTY MEDICAL SOCIETY

FREDERICK M. JOHNSON, M.D.

*Journal Representative*

**T**HE ANNUAL CHRISTMAS dinner party of the Charles County Medical Society was held at the Hawthorne Country Club in La Plata on December 19, 1959. The guest list included active members and their wives and a few of the busy members of the consulting staff of the Physicians Memorial Hospital in La Plata, among them Drs. Cobey, Fadeley, and Richwine, of Washington, and their wives; Dr. and Mrs. Thomas of Annapolis; Dr. and Mrs. Fadeley of Prince Frederick; Dr. Grugel of the Naval Propellant Plant in Indian Head; Dr. Villarosa, from the Philippine Islands, and his guest; Dr. Hogge, our dental representative, and his wife; Mr. Murphy, the hospital administrator. Of the members who at-

tended with their spouses were: Drs. Jarboe, Edelen, Andrews, Dettor, Wooddy, Griffin, Susan, and Johnson.

Recent developments in Charles County are centered around the possibility that, at long last, the new hospital will be built in the next year or two. The architectural firm of Ellerbe and Company is revising its plans for the first of what may be quite a few revisions. The projected hospital, if completed, will be of the most advanced design possible. Plans show a 30-bed unit in a circle around a central utility and nurses section. This will allow the nurses to actually see through the doorway of any room at any time, thereby eliminating many unnecessary steps. The outside of the building will have somewhat the appearance of a silo when these various units are stacked one on top of the other in future expansion. Since this is in the country, believe the local citizens won't be as upset about the silo-like appearance as some of our more urban friends might be. The big problem, however, isn't how it's going to look, but how much it's going to cost. There are tentative suggestions to the county commissioners for more money.

## DORCHESTER COUNTY MEDICAL SOCIETY

ALFRED R. MARYANOV, M.D.

*Journal Representative*

**A**T THE MEDICAL STAFF meeting of the Cambridge-Maryland Hospital, held on February 5, Albert E. Bunker, M.D., was re-elected chief of staff. The assistant chief of staff, Lawrence Maryanov, M.D., and the secretary-treasurer, Wilbur N. Baumann, M.D., were also re-elected.

At the meeting of the Cambridge-Maryland Hospital Board of Directors on February 15, the Board accepted the re-election of the staff officers, but only for a period of one month instead of one year as stipulated in the staff bylaws.

The Dorchester County Medical Society held its February meeting on February 17. Guest speakers were Carlos Cuccia, M.D., and Dr. Weisenberg, of the University of Maryland Radiotherapy Department.

The Society welcomed Jason Yee, M.D., who has begun the practice of medicine in Hurlock, Maryland.

## FREDERICK COUNTY MEDICAL SOCIETY

L. R. SCHOOLMAN, M.D.

*Journal Representative*

**T**HE REGULAR February meeting was held at the Francis Scott Key Hotel on February 16. Raymond L. Clemens, M.D., director of the Children's Evaluation Clinic at University Hospital, spoke on the multifaceted approach to the problems presented by children with multiple mental and physical handicaps. These complexities were well presented.

An additional representative to the House of Delegates of the Medical and Chirurgial Faculty, to which we are entitled by reason of more than 66 members, was elected. He is Frank Damazo, Jr., M.D. The alternates elected were Ernest Dettbarn, M.D., and Charles Conley, Jr., M.D.

The monthly Frederick Memorial Hospital medical staff seminar was held on the sixteenth. Dr. Thomas Stone, a local internist, presented an excellent paper on gout. Dr. Frank Davies, associate professor of medicine at the University of Maryland, was the discussant.



## MONTGOMERY COUNTY MEDICAL SOCIETY

CHARLES FARWELL, M.D.

*Journal Representative*

**P**AULA E. MAHLER, M.D., who died, is remembered well by all who knew her. This lovable Viennese doctor practiced in the Dutch East Indies and on the island of Kordula in the Adriatic Sea before practicing in Bethesda.

Dr. Willard P. McNeill's life was cut tragically short, thus depriving this area of a promising young surgeon. Like some of the best surgeons, Dr. McNeill became well experienced in the general practice of medicine for years before limiting his work to surgery. Many of us had the privilege of knowing his surgical efforts at Washington Sanitarium and Hospital since 1956; some of our colleagues in the Medical and Chirurgial Faculty will remember Dr. Willard's internship at Maryland General Hospital in Baltimore and his services as family doctor in Silver Spring from 1936 to 1948.

Timothy J. Tehan, M.D., wrote an interesting article on "Seminal Vesicle Cyst," which was published in our *Medical Bulletin*, thus adding the tenth report of a case of seminal vesicle cyst to American medical literature.

Dr. James H. Nelson, M.D., passed his certifying examinations for the American Board of Radiology.

At the scientific meeting, Dr. Richard F. Manegold, director of medical education at Sibley Hospital, discussed "Medical Education in Non-University Hospitals."

## WICOMICO COUNTY MEDICAL SOCIETY

GLADYS M. ALLEN, M.D.

*Journal Representative*

**A**T THE REGULAR meeting of the Wicomico County Medical Society on February 8, 1960, the guest speaker David Alexander, M.D., Pediatric Fellow in endocrinology at Johns Hopkins Hospital, spoke on "Abnormal Chromosomal Patterns."

## Medical Book Store



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# A VISIT TO



Miss Louise D. C. King, keeper of the library, a living fountain of knowledge.

## THE FACULTY OFFICE



Then there is that wizard of knowledge and finances, to say nothing of politics, Mr. Walter Kirkman.

Leslie E. Daugherty, M.D.



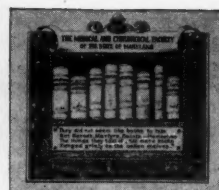
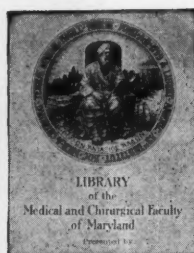
Dr. William Carl Ebeling, our genial secretary, and Mr. John Sargeant, executive secretary, confer before meetings of the Council.



Behind the scenes are special secretaries and record keepers, such as Mrs. Doris Gardner.



Consultations by the office staff are a-plenty, as shown here by Mrs. Adela Hannewald and Mrs. Erma Herget.



## Library

Louise D. C. King, *Librarian*

"Books shall be thy companions; bookcases and shelves,  
thy pleasure-nooks and gardens." *Ibn Tibbon*

## JOURNALS

A selected list of those currently received.

Please bear in mind we will be very happy to obtain anything not in our Library from other sources. Keep this list as a guide only.

Academy Bookman (New York Academy of Medicine)  
Academy of Medicine of New Jersey Bulletin  
Acta Cardiologia  
Acta Chirurgica Scandinavica  
Acta Medica Scandinavica  
Acta Ophthalmologica  
Acta Oto-Laryngologica  
Acta Radiologica  
Aerospace Medicine  
American College of Radiology Monthly News Letter  
American Heart Journal  
American Journal of Anatomy  
American Journal of Cardiology  
American Journal of Clinical Hypnosis  
American Journal of Clinical Nutrition  
American Journal of Clinical Pathology  
American Journal of Digestive Diseases  
American Journal of Diseases of Children (A.M.A.)  
American Journal of Gastroenterology  
American Journal of Human Genetics  
American Journal of Hygiene  
American Journal of Medicine  
American Journal of Obstetrics and Gynecology  
American Journal of Occupational Therapy  
American Journal of Ophthalmology  
American Journal of Orthodontics  
American Journal of Orthopsychiatry  
American Journal of Pathology  
American Journal of Physical Medicine  
American Journal of Physiology  
American Journal of Proctology  
American Journal of Psychiatry  
American Journal of Psychology  
American Journal of Psychotherapy

American Journal of Public Health  
American Journal of Roentgenology  
American Journal of Surgery  
American Journal of the Medical Sciences  
American Practitioner and Digest of Treatment  
American Review of Respiratory Diseases  
American Surgeon  
Anaesthesia  
Anesthesia and Analgesia  
Anesthesiology  
Angiology  
Annals of Allergy  
Annals of Internal Medicine  
Annals of Otolaryngology, Rhinology and Laryngology  
Annals of Surgery  
Annals of the New York Academy of Sciences  
Annals of the Rheumatic Diseases  
Antibiotics and Chemotherapy  
Archives of Biochemistry and Biophysics  
Archives of Dermatology (A.M.A.)  
Archives of Diseases in Childhood  
Archives of General Psychiatry (A.M.A.)  
Archives of Industrial Health (A.M.A.)  
Archives of Internal Medicine (A.M.A.)  
Archives of Neurology (A.M.A.)  
Archives of Ophthalmology (A.M.A.)  
Archives of Otolaryngology (A.M.A.)  
Archives of Pathology (A.M.A.)  
Archives of Pediatrics  
Archives of Physical Medicine  
Archives of Surgery (A.M.A.)  
Arizona Medicine  
Arthritis and Rheumatism  
Bacteriological Review  
Biochemical Journal  
Blood

Brain  
 British Heart Journal  
 British Journal of Anaesthesia  
 British Journal of Clinical Practice  
 British Journal of Dermatology  
 British Journal of Experimental Pathology  
 British Journal of Industrial Medicine  
 British Journal of Ophthalmology  
 British Journal of Plastic Surgery  
 British Journal of Radiology  
 British Journal of Surgery  
 British Journal of Urology  
 British Medical Bulletin  
 British Medical Journal  
 Bulletin of the American College of Surgeons  
 Bulletin of the History of Medicine  
 Bulletin of the Johns Hopkins Hospital  
 Bulletin of the Joint Commission on Accreditation  
 of Hospitals  
 Bulletin of the Los Angeles County Medical Society  
 Bulletin of the Los Angeles Neurological Society  
 Bulletin of the Medical Library Association  
 Bulletin of the Menninger Clinic  
 Bulletin of the New York Academy of Medicine  
 Bulletin of the Tufts-New England Medical Center  
 California Medicine  
 Canadian Journal of Public Health  
 Canadian Medical Association Journal  
 Canadian Psychiatric Association Journal  
 Cancer  
 Cancer Research  
 Cardiology  
 Central African Journal of Medicine  
 Ciba Clinical Symposia  
 Cincinnati Journal of Medicine  
 Circulation  
 Circulation Research  
 Citation  
 Cleveland Clinic Quarterly  
 Clinical Medicine  
 Clinical Orthopedics  
 Clinical Pharmacology and Therapeutics  
 Clinical Proceedings of the Children's Hospital  
 (Washington, D. C.)  
 Clinical Science  
 Dallas Medical Journal  
 Delaware State Medical Journal  
 Denta Clinics of North America  
 Diabetes  
 Digest of Neurology and Psychiatry  
 Diseases of the Chest  
 Diseases of the Colon and Rectum  
 Diseases of the Nervous System  
 Electroencephalography and Clinical Neurophysi-  
 ology  
 Endocrinology  
 Excerpta Medica (all)  
 Eye, Ear, Nose and Throat Monthly  
 Federation Proceedings  
 Fertility and Sterility  
 Gastroenterology  
 General Practitioner (GP)  
 Geriatrics  
 Group Practice  
 Guthrie Clinic Bulletin  
 Guy's Hospital Reports  
 Harper Hospital Bulletin (Detroit)  
 Hawaii Medical Journal

Henry Ford Hospital Medical Bulletin  
 Hospitals  
 Human Biology  
 Illinois Medical Journal  
 Industrial Medicine and Surgery  
 International Journal of Anesthesia  
 Irish Journal of Medical Science  
 Japanese Journal of Experimental Medicine  
 Journal-Lancet  
 Journal of Allergy  
 Journal of Bacteriology  
 Journal of Biological Chemistry  
 Journal of Bone and Joint Surgery (A & B)  
 Journal of Chronic Diseases  
 Journal of Clinical Endocrinology  
 Journal of Clinical Investigation  
 Journal of Clinical Pathology  
 Journal of Endocrinology  
 Journal of Experimental Medicine  
 Journal of General Physiology  
 Journal of Gerontology  
 Journal of Heredity  
 Journal of Hygiene  
 Journal of Immunology  
 Journal of Infectious Diseases  
 Journal of Investigative Dermatology  
 Journal of Laboratory and Clinical Medicine  
 Journal of Laryngology and Otology  
 Journal of Medical Education  
 Journal of Nervous and Mental Disease  
 Journal of Neurology, Neurosurgery and Psychiatry  
 Journal of Neurophysiology  
 Journal of Neurosurgery  
 Journal of Nutrition  
 Journal of Obstetrics and Gynecology of the British  
 Empire  
 Journal of Parasitology  
 Journal of Pathology and Bacteriology  
 Journal of Pediatrics  
 Journal of Pharmacology and Experimental Thera-  
 peutics  
 Journal of Physiology  
 Journal of the American Dental Association  
 Journal of the American Geriatric Society  
 Journal of the American Medical Association  
 Journal of the American Medical Women's Asso-  
 ciation  
 Journal of the American Pediatrics Association  
 Journal of the Arkansas Medical Society  
 Journal of the Florida Medical Association  
 Journal of the History of Medicine  
 Journal of the Indiana State Medical Association  
 Journal of the International College of Surgeons  
 Journal of the Iowa State Medical Society  
 Journal of the Kansas Medical Society  
 Journal of the Kentucky State Medical Association  
 Journal of the Louisiana State Medical Society  
 Journal of the Maine Medical Association  
 Journal of the Medical Association of Georgia  
 Journal of the Medical Association of the State of  
 Alabama  
 Journal of the Medical Society of New Jersey  
 Journal of the Michigan State Medical Society  
 Journal of the Mount Sinai Hospital (N. Y.)

(to be continued next month)

KEEP THIS NUMBER FOR FUTURE  
 REFERENCE



# Maryland

## SOCIETY OF PATHOLOGISTS INC.

LOUIS B. THOMAS, M.D., *President*

EDWARD C. MCGARRY, M.D., *Secretary*

Suburban Hospital, Bethesda, Md.



### TIME AND TRANSFUSION SAFETY

**H**OW MUCH TIME is required by the blood bank to process a unit of blood for transfusion? Does haste compromise transfusion safety?

The transfusion safety of human whole blood varies, in part, with the time available for securing the most compatible donor blood. A shortening of this time interval may result in errors of varying degree; however, practical considerations, as dictated by the situation, sometimes preclude a leisurely compatibility technique.

The cross-match procedure which is currently recommended, although it is time consuming, is an elaborate technique designed to produce the safest possible unit of blood. Briefly, the technique consists of three phases: (1) the first phase is performed at room temperature in a protein diluent and serves to unmask incompatibility in the ABO system and, occasionally, to reveal a high-titre anti-Rh antibody which may show the prozone phenomenon at body-temperature incubation; (2) the second phase, which is incubation at body temperature, is designed to show incompatibility due to low titre anti-Rh or anti-Hr antibodies or to any other antibody which requires incubation at 37° C.; (3) the third phase entails the performance of a Coombs test (which uses rabbit or goat anti-human serum) on the unagglutinated or unhemolyzed erythrocytes from the second phase. The Coombs test reveals the presence of clinically important antibodies seldom detected by other methods; i.e., anti-Kell, anti-Lewis, anti-Duffy, anti-Kidd.

Time is required, of course, to secure the blood specimen, to allow the specimen to clot, to separate the serum from the clot, etc., but the most time consuming procedure by far, when ample time is available, is the period of incubation at body temperature. From controlled studies it appears that one hour is the optimum period of incubation to reveal the maximum amount of antibody information. Some blood banks and other laboratories, however, have routinely shortened the incubation period to as little as 15 minutes, in the conviction that most of the antibodies are revealed in this period of time.

There is no question that in clinical situations of a compelling nature it is neither desirable nor wise to allow the usual protracted period for "setting-up" a unit of blood. In such instances the clinician must decide how much time the blood bank may have to produce a compatible unit of blood. When a moderate degree of urgency prevails, the incubation period can be shortened to 15 minutes instead of the usual one hour; when a more urgent situation exists, the blood bank may, of



necessity, shorten the cross-match procedure to a room-temperature compatibility test, possibly including the use of bromelin (a proteolytic enzyme obtained from pineapple stalks, which appears to enhance the detection of atypical antibodies).

Under catastrophic circumstances the need for blood may be so great that there is not enough time for any of the above techniques. In such situations, Group O blood of low titre (less than 1:200), to which specific substance has been added, is used without *any* cross-match.

The choice of how much time is available; that is, how soon the patient *needs* to have the blood, is the responsibility of the clinician alone, but it is vital for all others concerned to realize that to demand blood within a shorter period of time than that which has been established as optimal may be deleterious to the patient's welfare; for haste sharply reduces transfusion safety.

### Physician Identification

The blue cross supplied by the Baltimore Police Department has been in use for many years to identify physicians' automobiles. This emblem is not required; although some physicians feel obliged to display it or to use other identification tags, such as the caduceus. Aside from the prestige which such emblems may give, the only advantage of such identification is the right to park in areas restricted for the use of physicians.

On the other hand, there are many potential disadvantages in displaying such an identification tag: when a car is identified as belonging to a physician, the public quite naturally assumes the driver of the car to be typical of the medical profession. If he is a poor driver, or a reckless driver, or a discourteous driver, then all physicians tend to be labeled as such. If the car is a Cadillac or an Imperial, then all physicians are considered rich; if the car is a sports car or a foreign car, then all physicians are sports. Thieves are more apt to break into a physician's car than another vehicle, attempting to obtain drugs and other medical supplies from the physician's bag. Law enforcement officers in other states are more apt to stop a physician, because they are certain there will be no problem about payment of a fine.

When identification is necessary, the blue cross or other emblem can be displayed in the windshield or on the visor. However, physicians should reconsider permanent display of professional symbols. Such identification certainly should not appear on vehicles used by the doctor's wife or family. To display this identification on a car which is not in use for medical purposes is certainly bad public relations, and it is often bad public relations to display it at all.



## BALTIMORE CITY HEALTH DEPARTMENT

HUNTINGTON WILLIAMS, M.D.  
COMMISSIONER

P. O. Box 1877 Baltimore 3, Md.

Plaza 2-2000; Extension 307

Learn To Do Your Part In The Prevention Of Disease

### Concerning Community Respiratory Illnesses

**I**N HIS *Saturday Letter to the Mayor* on February 5, the Commissioner of Health wrote in regard to the winter episode of respiratory illness sweeping across the city as follows:

At this season the City Health Department is frequently asked to comment on the current episode of respiratory illness sweeping across the city. Its presence in our midst is surely known to everyone.

My own feeling about it, and I believe this is shared by the State health authorities, is that while it is disabling to various individuals for a

few days each, it is not different from the normal seasonal appearance of this same type of illness. Year after year it makes its regular appearance, usually in October or November and again in February, when the temperature goes suddenly up or down and when it is apt to be wet under foot.

From a report just completed by Mr. Todd M. Frazier, director of our Bureau of Biostatistics, I learn that data secured from the Baltimore Health Survey show that 22 per cent of the scattered city sample of persons interviewed had this respiratory illness during the first half of January. This is at least three times the respiratory illness rate as compared with a similar two week period covering the last half of December. The February sample of the Baltimore Health Survey will provide further information about the extent of this illness during the last half of January.

Death records show that the number of influenza and pneumonia deaths has been close to or slightly exceeded the seven year high for each of the four weeks in January. School absentee rates for the last two weeks of January are at the levels expected for this time of year and thus would seem to indicate that high rates of illness were not experienced by the school age population.

In general, it would appear that the current outbreak of respiratory illness in Baltimore so far is by no means as extensive as that which visited the city in the fall and winter of 1957-1958, nor has this present visitation manifested itself with the same degree of severity. Persons with a cold and fever should stay in bed."

*Huntington Williams, M.D.*

Commissioner of Health

The 1960 officers, who were elected at the annual meeting of the Maryland Society on Alcoholism, held January 26, 1960, at the Medical and Chirurgical Faculty Building, are:

President: Dr. Fernando J. Cabrera

First Vice-president: Dr. Newland E. Day

Second Vice-President: William deV. Washburn

Secretary: John McGrath

Assistant Secretary: Mrs. Dorothy Goodman

Treasurer: Arthur D. Pratt, Jr.

Plans for the coming year include the establishing of a budget of \$35,000 to finance an information center to coordinate the numerous efforts within the State to cope with the problem of alcoholism and to disseminate to the public pertinent information on alcoholism.



# Blue Cross - Blue Shield



## The Blue Cross "Diagnostic Admission"

Denwood N. Kelly\*

**P**ROBABLY THE SINGLE most difficult area of Blue Cross claims administration concerns the so-called "diagnostic admission."

The Blue Cross Membership Certificate specifies that coverage is not provided for "inpatient hospitalization primarily for diagnosis, diagnostic study or medical observation (even though therapy directed toward relief of symptoms may be rendered) when necessary care can be provided on an ambulatory outpatient basis and the condition of the subscriber or the nature of the procedure does not necessitate that the subscriber be hospitalized as a bed patient."

Blue Cross attempts to enforce this provision precisely as it is written; that is, it tries to determine if the care rendered could have been provided on other than an inpatient basis without danger to the patient or actual impairment of the effectiveness of the diagnostic procedures undertaken.

To the best of our knowledge, commercial insurance hospitalization policies do not attempt to exclude benefits for "diagnostic admissions." Rather, their claims determination is based simply on whether the patient remained in the hospital for 18 hours or more. Blue Cross has always felt it advisable to retain this exclusion as one deterrent to the uneconomical use of hospital facilities.

The principle difficulty which Blue Cross encounters in the administration of this exclusion is simply its inability to obtain adequate information when such cases are questioned. Admittedly, the "form" questionnaires which Blue Cross sends to physicians may not contain the precise

questions which the recipients think would be most pertinent in every case. However, factual answers to these questions in most instances will enable Blue Cross to settle the claim properly. Nevertheless, if other pertinent factors are involved, the physician, in fairness to his patient, should bring them to the attention of Blue Cross. All too frequently the key factor in a case does not emerge until someone protests a denial of care.

The request by Blue Cross for information regarding such admissions does not mean that by the mere fact that it questions a doctor about such admissions, Blue Cross in any way questions the physician's professional integrity. Blue Cross realizes that many factors may prompt a physician to admit a patient to a hospital in cases of this nature; but these reasons are not always apparent unless the physician presents them in an adequate manner. Blue Cross wants to consider *all* factors in a case, but its decision must be based on whether the patient actually is entitled to coverage under the terms of the Membership Certificate.

What can doctors do to help? When Blue Cross asks for information, he can make his replies as accurate and as complete as possible. If he is pressured by a patient to admit him to the hospital for diagnostic studies because he has Blue Cross, he should answer him in somewhat this fashion:

**"The studies needed do not require you to stay in the hospital overnight; they can be done just as well in the hospital laboratory or in a doctor's office. Even if I do admit you to the hospital, Blue Cross does not cover this type of care, and I will have to be completely factual when the claim is questioned."**

If he does not tell him this, he will be less than fair to his patient. Moreover, the unnecessary admission may cause an acutely ill person to be denied the hospital care he badly needs because a bed is not available.

\* Assistant Director, Maryland Medical Service, Inc.



## MARYLAND TUBERCULOSIS ASSOCIATION

Christmas Seal Agency for State of Maryland

900 ST. PAUL STREET

BALTIMORE 2, MARYLAND

### The Natural History Of Emphysema In Man

**T**HE TRADITIONAL method of classification of emphysema is based on clinical-pathological correlation. This method has severe limitations. The pathology of emphysema is not an all or none phenomenon. One can state with some assurance that a patient has or has not bronchogenic carcinoma or pulmonary tuberculosis. In the case of emphysema the degree of change in the lung may range from a few bullae or dilated air spaces to a condition in which both lungs may be almost entirely replaced by bullae. In emphysema the pathology must be defined quantitatively as well as qualitatively.

There are other problems related to the pathologic definition of emphysema. Most pathologists do not fix the lungs in an inflated state. Hence, the gross and microscopic evaluation of the disease lacks precision. The pathologic process is not accurately reflected in the roentgenogram and we must await the death of the patient for an accurate appraisal of the changes in the lung.

For these reasons clinicians have begun to rely more and more on a physiologic definition of emphysema. Unfortunately, the data are not available to correlate precisely this physiologic definition of the disease with the pathologic definition.

The chief symptom of emphysema is dyspnea beginning as exertional dyspnea. The patient notes that his activity is being limited progressively because of shortness of breath. Often this limitation of activity is attributed to aging or loss of physical fitness. Finally the patient is unable to walk even a short distance without being tortured by dyspnea. Episodes of dyspnea occur at rest and are accompanied by wheezing. These acute epi-

Richard V. Ebert, M.D.

sodes, often referred to as "asthma," are usually precipitated by an upper respiratory infection. Administration of adequate amounts of antimicrobial drugs usually gives dramatic relief.

Cough is a persistent symptom in most patients with emphysema. The sputum production is greatest following a respiratory infection. Many patients with emphysema have a slight decrease in the oxygen saturation of the hemoglobin of the arterial blood and a slight increase in carbon dioxide tension. There appears to be little correlation between the degree of hypoxia and the severity of the dyspnea.

The most serious threat to the life of the patient with emphysema is the sudden increase in hypoxia and hypercapnia which accompanies an exacerbation of the bronchitis. He has a sudden increase in dyspnea and becomes cyanotic and often disoriented and confused. Cough and fever may be absent, and secretions accumulate in the trachea and bronchi. Administration of oxygen may lead to improvement, or the patient may lapse into coma as a result of an increase in carbon dioxide tension in the arterial blood and resultant respiratory acidosis. Death may occur if treatment is not prompt and effective.

Right heart failure is commonly found in these patients and is manifested by cardiac enlargement, elevated venous pressure, and hepatomegaly. There is no evidence to indicate that this adversely influences the function of the lungs. The heart failure is usually not chronic but clears when the acute bronchial infection subsides and the hypoxia improves.

The prognosis of emphysema is not well defined. In part this is related to difficulties of

Reprinted from *The American Review of Respiratory Diseases*, July, 1959 and Abstracts on Tuberculosis and Other Respiratory Diseases, issued by the National Tuberculosis Association, January, 1960.



classification and definition. There are a number of patients who apparently have emphysema but who do not follow the classical clinical course just given.

One of the controversial aspects of emphysema is its relationship to bronchial asthma. A number of patients with typical emphysema will give a previous history of bronchial asthma. The episodes of dyspnea accompanying acute bronchial infection in emphysema are difficult to differentiate from true bronchial asthma. Hence it is difficult to determine whether previous episodes were asthma or bronchitis. The incidence of pulmonary emphysema in patients with known bronchial asthma is also difficult to establish. The relationship between bronchial asthma and emphysema needs further clarification.

A similar problem exists in the relationship between chronic bronchitis and emphysema. It is clear that chronic bronchitis is often associated with pulmonary emphysema and that acute bronchial infection precipitates the more severe episodes of dyspnea and hypoxia.

There also appears to be a relationship between bronchiectasis and emphysema. A mild cylindrical dilatation of the bronchi is found on the bronchograms of many patients with emphysema, but certain patients have the findings of sacular bronchiectasis. The bronchiectasis precedes by some years the symptoms of emphysema. Moreover, a number of patients with severe bilateral bronchiectasis develop pulmonary insufficiency. There also appears to be an undue incidence of diffuse pulmonary emphysema complicating other chronic inflammatory diseases of the lung. A focal type of emphysema has been described in the lungs of coal miners.

Certain changes in pulmonary function occur with aging. There is a decrease in vital capacity and an increase in residual volume in association with a change in the elastic properties of the lungs. These elderly persons have no respiratory symptoms but if such persons develop bronchitis, the physiologic findings could readily be confused with emphysema.

Many patients with emphysema will demonstrate an increase in the anteroposterior diameter of the chest associated with hyperresonance to percussion and a tendency to obliteration of the cardiac and hepatic dullness. Similar changes occur in many elderly persons without emphysema.

Moreover, some patients with emphysema do not exhibit this phenomenon. It would appear that the barrel-chest phenomenon is related to aging changes in the skeleton. For some reason it tends to occur prematurely in patients with emphysema.

## *Book Reviews*

**What Next, Doctor Peck?** Joseph H. Peck, M.D., Englewood Cliffs, N. J., Prentice-Hall, Inc., 1959.

On the lighter side is this autobiography of a physician who began his medical practice in frontier territory of the Old West. A strange cast of characters paraded through his life, and he relates his experiences with warmth and humor.

**Living Beyond Your Heart Attack**, Eugene B. Mozes, M.D., Englewood Cliffs, N. J., Prentice-Hall, Inc., 1959.

As a practicing heart specialist, Dr. Mozes presents an encouraging outlook for today's victims of heart attacks. His book is written to dispel the fears and myths held by many lay people about heart attacks and to show how they can safely replan their lives for normal, active living.

**A Cookbook for Diabetics**, Deaconess Maude Behrman, New York, The American Diabetes Association, 1959.

An inclusive collection of appetizing and well-balanced menus and recipes for diabetic diets has been compiled in book form. The author is consulting dietitian to *ADA Forecast* and prepares the magazine's articles on diet. This cookbook is the outgrowth of a 12-year series of precisely described, scientifically planned recipes and menus for diabetics and their families and guests.

**Synopsis of Ear, Nose and Throat Diseases**, Robert E. Ryan, M.D., William C. Thornell, M.D., and Hans von Leden, M.D., St. Louis, The C. V. Mosby Company, 1959.

A digest of the common ailments within the ear, nose and throat specialty is presented here as a handy guide and ready reference for the family physician, student, nurse, and speech or voice pathologist. The common diseases affecting the ear, nose, pharynx and larynx are discussed in relation to their etiology, pathology, symptomatology, prognosis and therapy, and the symptoms and treatment of more common conditions are repeated in outline form at the end of each chapter.

**Atlas of Roentgenographic Positions**, ed. 2, vols. 1 and 2, Vinita Merrill, St. Louis, The C. V. Mosby Company, 1959.

A reference book for x-ray technicians, these two volumes describe many unusual and specialized roentgenographic positions, as well as the standard ones. It presents information pertaining to anatomy and physiology, definitions of roentgenological terms and a bibliography for further study.



## THE MARYLAND ACADEMY OF GENERAL PRACTICE

(A constituent chapter of the American Academy of General Practice)

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## A Certifying Board In General Practice?

THE AMERICAN ACADEMY of General Practice has had a committee studying the question of a certifying board in general practice during the past two years. A joint committee of the Academy and the American Medical Association's General Practice Section was formed in August 1958. Its purpose was "to consider the feasibility of establishing an examining board that would evaluate the competence of family physicians of the future." Such a Board of General Practice would be for the primary purpose of recognizing, encouraging and rewarding better preparation and education of physicians for general practice. It is a question of great importance and great complexity.

There are, indeed, advantages to the formulation of such a Board.

Of first importance is the fact that there is a public demand for family physicians. The diplomate of such a board of general practice would be recognized as the family physician whose general function is implied in his title and whose specific duties would be determined by his training and by local needs and customs. Secondly, elevation of the standards of training for general family prac-

tice to the level of other fields in medicine would be stimulated and encouraged, thereby placing its diplomates in a more realistic position in relation to their colleagues in other fields.

In contemporary America the possession of a diploma, certificate, award or other evidence of achievement has become in the minds of the general public a necessary testament to education, formal or otherwise.

If such a certification board is formed, it is the intention of the Academy to continue its present system of postgraduate study requirements. Certification would be for a specified time rather than a lifetime award. Postgraduate study is the primary means of improving and maintaining competence among Academy members, and some means of assuring continued study must be provided.

Information on the preliminary studies of committees concerning the proposal of a certifying board was presented in San Francisco at the last annual meeting. The committee report was summarized and has been presented for the thoughtful consideration of members of the Academy of General Practice.

### CAMP DOCTORS NEEDED

Camp Louise for girls and Camp Airy for boys, situated in the Blue Ridge Mountains of Maryland, are eager to secure medical staff for the summer months.

If graduate physicians are not available, third year medical students will be acceptable. They can take care of married couples, but not with very young children. They can also place several nurses.

Interested applicants may write to the Baltimore office, 641 North Eutaw Street, Baltimore 1, Maryland.

## MEDICARE PROGRAM—1960

**T**HE following information pertains to the restored program for the dependents of service personnel, effective January 1, 1960. The material has been condensed from several Army bulletins, and the Office of the Surgeon General of the Army has requested that it be published in this journal.

### IMPORTANT

#### I. SURGERY

The restored Medicare Program now provides for surgery necessary for improvement of body function: T&A, D&C, tendon transplants, and similar procedures consistent with the practice of good medicine. Such procedures as rhinoplasties and mammoplasties are allowable only when the surgery is for the improvement of breathing or the relief of extreme discomfort. Procedures done for other than the improvement of body function, such as salpingoplasty for sterility, or the removal of tattoos, are not allowable at government expense; surgery for purely cosmetic or psychological reasons still remains the responsibility of the patient.

#### II. OUTPATIENT CARE

Outpatient care for accidental injury, poisoning, and inhalation of gas is now allowable at government expense, with the patient paying the first \$15.00 of the physician charges. The government will pay up to \$75.00 for pre-hospitalization tests and procedures in surgical cases and up to \$50.00 for post-hospitalization tests and procedures in surgical cases; the patient is not required to pay any part of the charge up to \$75.00 and \$50.00, respectively.

#### III. CHANGE IN NAME OF FORM

The title of DD Form 1251 has been changed to the more descriptive "Non-availability Statement, Dependents' Medical Care Program." Forms bearing the word "Permit" are still acceptable for non-emergency care provided to those who reside with their active duty sponsors. DD Form 1251 is not a requirement for emergency cases.

#### IV. IDENTIFICATION INFORMATION FOR ALL SERVICES STARTED AFTER MARCH 1, 1960

The Army has advised that the Medical Authorization Card, DD Form 1173, is now valid only from the date of issue up to the expiration date. Cards bearing an expired date, no date, or the word "indefinite" or abbreviation thereof, are not acceptable. In the absence of an acceptable card, special provisions apply to emergency cases. Payment for care in emergencies can be made if the reason for the absence of a valid card is stated and if (1) a local military commander certifies as to eligibility, or (2) official documents reflect eligibility, or (3) statement by hospital or physician certifies personal knowledge of eligibility as spouse or child, or (4) social security number, or (5) state and number of driver's license is obtainable from the patient or person signing the Statement of Services provided (DA Form 1863).

In cases that do not, in the opinion of the attending physician, constitute an emergency and no valid card is presented, the patient should be accepted only as a potential beneficiary under the Program. Under these conditions the patient is required to obtain a statement from a military official authorized to issue Medical Authorization Cards, DD Form 1173.

These regulations also apply to cards presented by parents of children under age 10, but do not apply in cases where the patient is eligible for maternity care after the husband's death, in which case a special letter of authorization is adequate.

#### V. BLOOD

The government provides for payment to hospitals for blood provided patients but requests physicians to urge friends and relatives of patients to donate blood in order to avoid depletion of the hospital supply.

#### VI. ASSISTANCE FROM BLUE SHIELD

As fiscal agent, the Maryland Blue Shield Plan will gladly assist physicians and hospitals in establishing identity and in difficult or unusual cases.

## Dear Doctor

### Deterioration of Nursing Services in the past Twenty Years

In April, 1958 *Current Medical Digest*, and in July, 1958 *MARYLAND STATE MEDICAL JOURNAL* appeared two articles by Dr. Amos R. Koontz. The first was titled "When is a Nurse not a Nurse," and the second, "What has Happened to Nursing?" Because of a series of experiences I have encountered during the past year in several of our leading hospitals, I, with much regret, must substantiate Dr. Koontz's criticism of nursing as it is today.

For over fifteen years, until two years ago, I have been engaged in public health and industrial nursing, having had, during that period, little contact with the hospitals. During the past two years, however, when certain friends of mine were patients, I had time to observe, while visiting and assisting them, how terribly nursing care had deteriorated since the time I had been employed as a head nurse in a hospital.

I will mention only a few important ones of the very numerous occurrences that were detrimental to patient care.

- (1) The head nurse did not make rounds, either morning or evening, to talk with and observe the patients on her floor. The patient I visited, a seriously ill woman, had seen the head nurse only once, after being a patient for ten days.
- (2) The patient was left unattended, while receiving continuous intravenous fluids, with the result that for hours at a time, the fluid ceased to run into the veins. When the apparatus needed adjustments, the nurses were unable to fix it and had to call the interne, who could not come for several hours on one occasion, and for an entire night on another occasion.
- (3) The patient would be given a bed pan, following which there was no attempt to let her wash her hands. The only opportunity for washing was in the morning.
- (4) The patient was finally permitted to have an ice bag for continuous headaches. When such an ice bag arrived, it was so large and heavy that the patient couldn't stand the

weight of it. Her husband went out and purchased a smaller, lighter, variety.

- (5) The nursing aides were crude, untrained and unsupervised. They were noisy, unprofessional and, on the whole, rather disgusting.
- (6) The patient (in a semi-private room) seldom saw a nurse. Most of her contacts were with untrained, unsupervised, non-professional people.

So, regretfully, I ask, along with Dr. Koontz, "What Has Happened to Nursing?"

Bertha M. Gomprecht, R.N.  
January, 1960

### Sale of Dihydrocodeinone

To: Physicians  
Pharmacists  
Authorized Dealers in Narcotic Drugs

Demands for products containing dihydrocodeinone have been made by purchasers with such frequency that its use for a medical need has been questioned. Because of the manner in which such persons operate; i.e., use of several aliases, several addresses, and devious forms of identification, and because dihydrocodeinone has been abused to create euphoria, and a substitute for the more potent narcotic drugs, etc., the State Board of Health has passed the following regulation:

Pursuant to authority conferred upon the State Board of Health by Sections 284, 286 and 299, Article 27, Annotated Code of Maryland (1957 Edition), the following regulation, governing the sale of dihydrocodeinone or any of its salts, is hereby established as a minimum requirement of the State Board of Health:

*Dihydrocodeinone or any of its salts in any preparation is hereby restricted to sale on prescription only, in accord with the State Board of Health's "Regulations Governing Acceptance of Oral Prescriptions for Certain Narcotic Drugs."*

The above regulation applies to such commonly branded items as Cosanyl®, Tussar®, Endotussin®, Coricidin® Syrup, Bucol®, Dekal®, and all imprinted goods, etc.

The regulation became effective April 1, 1960.  
F. S. Balassone, Chief  
Division of Drug Control  
State Department of Health



## CALENDAR OF EVENTS

### ► Tuesday, April 19 ◄

#### CARDIAC NURSING SEMINAR

9 A.M. to 5 P.M.

Sponsored by The Heart Association of Maryland,  
The Maryland Nurses Association, and  
The Maryland League for Nursing.

### ► Sunday, April 24 ◄

#### SINAI HOSPITAL DOCTORS' DEDICATION EXERCISES

Scientific program at Sinai Hospital.

### ► Tuesday, April 26 ◄

#### MARYLAND CHAPTER, INTERNATIONAL ASSOCIATION FOR DENTAL RESEARCH

8:00 P.M. Hall 37, Baltimore College of Den-  
tal Surgery, Lombard and Greene  
Streets, Baltimore, Maryland  
Program of Dental Research

### ► Wednesday, April 27 ◄

#### UNION MEMORIAL HOSPITAL SCIENTIFIC MEETING

5:00 P.M. NURSES AUDITORIUM  
Robert W. Buxton, M.D., "Portal Hypertension."

### ► Thursday, April 28 ◄

#### POSTGRADUATE COURSE IN PULMONARY DISEASES

8:15 A.M. Registration, Postgraduate Committee  
Office, Davidge Hall, University of  
Maryland School of Medicine  
9:00 A.M. Scientific Papers, Room 171, Psychi-  
atric Institute, 645 West Redwood  
Street, Baltimore 1, Maryland

#### MARYLAND TUBERCULOSIS ASSOCIATION

10:00 A.M. Community Hall, Harundale Mall,  
Glen Burnie, Md. Fifty-sixth annual  
meeting

### ► Friday, April 29 ◄

#### POSTGRADUATE COURSE IN PULMONARY DISEASES

9:00 A.M. Room 171, Psychiatric Institute, 645  
West Redwood Street, Baltimore 1,  
Maryland

#### MARYLAND TRUDEAU SOCIETY

6:30 P.M., Southern Hotel  
First Annual Meeting

#### VIRGINIA BEYER MEMORIAL LECTURE

8:00 P.M. Conference Room, Medical Surgical  
Building, Springfield State Hospital  
Lawrence S. Kubie, M.D., "The Neurotic Process  
as the Crossroads of Joint Organic and Psychologi-  
cal Genesis and Inquiry."

### ► Saturday, April 30 ◄

#### LUTHERAN HOSPITAL MEDICAL ASSOCIATION

10 to 12 A.M. Nurses Residence, Lutheran Hos-  
pital of Maryland

#### THE TIARA BALL

(Woman's Auxiliary to the Baltimore City  
Medical Society)

Blue Crest North, 401 Reisterstown Road

7:00 P.M. Champagne Hour

8:00 P.M. Dinner

Music by Feen Iula

### ► Tuesday, May 3-Friday, May 27 ◄

#### POSTGRADUATE INSTITUTE OF DOCTORS HOSPITAL

"Aging—Physiology, Pathology and Treatment."  
Advance Registration required.

### ► Friday, May 6 ◄

#### BALTIMORE CHAPTER, NATIONAL CYSTIC FIBROSIS RESEARCH FOUNDATION

8:00 P.M. Belvedere Armory, Belvedere Avenue  
and Reisterstown Road

### ► Monday, May 9-Friday, May 13 ◄

#### MERCY HOSPITAL DEPARTMENT OF MEDICINE: CARDIOVASCULAR DIAGNOSIS

9:00 A.M.-3:00 P.M. Mercy Hospital

### ► Tuesday, May 10 ◄

#### MARYLAND SOCIETY ON ALCOHOLISM

8:00 P.M. 22 Light Street

### ► Wednesday, May 11 ◄

#### MONTGOMERY COUNTY TUBERCULOSIS AND HEART ASSOCIATION

Second Annual Heart Symposium  
National Institutes of Health, Bethesda, Maryland

#### CANCER SECTION, B.C.M.S.

7:00 P.M. Dinner 8:00 P.M. Meeting  
U.S. Public Health Service Hospital

#### MARYLAND SOCIETY FOR MENTALLY RETARDED CHILDREN

(Greater Baltimore Chapter, Inc.)

8:15 P.M. 2525 Kirk Avenue, Baltimore 18,  
Maryland

### ► Thursday, May 12 ◄

#### MARYLAND ACADEMY OF GENERAL PRACTICE

Postgraduate Day  
1:30 P.M. and 9:00 P.M. Doctors Hospital



# Woman's Auxiliary

## Medical and Chirurgical Faculty

MRS. E. RODERICK SHIPLEY Auxiliary Editor



APRIL, 1960

### News Notes

A few members of the State and Baltimore City Auxiliaries are attending the Baltimore Conference on Aging March 30-31st.

The Future Nurse Clubs of Prince George's and Baltimore Counties have held county wide meeting which were most successful. They held a delegates meeting at the Faculty Building on February 27th to make plans for the Annual Convention in May.

The Baltimore County Auxiliary is holding their annual Doctor's Day Dinner Dance at the Belvedere Hotel on April 2nd. All are welcome to attend. Proceeds will go toward their scholarship fund.

The Gastineau Trophy, a beautiful silver bowl, will be given to the State having the greatest per capita contributions to A.M.E.F., at the Annual A.M.A. Convention in Miami. This trophy will be passed on year to year and the date and state name will be inscribed. Three certificates will be given at our own convention in April to counties having the greatest per capita rate according to their size.

#### PRESIDENTS TRAVELOGUE

Our President, Mrs. D. Delmas Caples, and our President-elect, Mrs. William S. Stone will be guests of the Pennsylvania Auxiliary at their annual conference in Harrisburg in March. They will be guests of the New Jersey Auxiliary at their annual Meeting in New Jersey May 14-17th.

Mrs. Caples is making her official visits to Washington, Montgomery, and Carroll Counties, also to Baltimore City Auxiliaries in March.

### Medical Research Committee

Lee B. Kolodner

For the third year, the Medical Research Committee of The Woman's Auxiliary to The Baltimore City Medical Society has assisted the Maryland Society for Medical Research (MSMR) in its "Small Animal Classroom Project."

Under the supervision of its secretary, Dr. Dietrich C. Smith, the MSMR supplies small laboratory animals, such as guinea pigs, hamsters, rabbits, and white rats, to classrooms throughout the state upon request from the teachers. They are used in the elementary grades primarily for simple care and feeding. In the junior and senior high schools, the students perform simple nutritional and genetic experiments. One of the major purposes of this project is aimed at educating the public on the need for animals in the advancement of medical research. It follows the nationwide program of stimulating scientific interest in the schools.

Our Auxiliary committee functions in the realm of good public relations by visiting these classrooms for MSMR, noting the condition and care of the animals, evaluating the project, and helping the teachers solve any problems related to the study under consideration.

At an Auxiliary meeting in September, 1959, Mrs. Louis Kolodner and Mrs. Stanley Steinbach, co-chairmen of the visiting group, exhibited some of the results of previous years' classroom projects. The purpose of the exhibit, which was prepared by MSMR, was to explain the work and to interest prospective committee workers. Thirteen auxiliary members were intrigued and volunteered their services. In October, committee members met with Dr. Smith in the animal lab of the Bressler Research Building for further

orientation of the project and of their specific responsibilities.

Requests from the teachers for these animals have been steadily increasing each year, thus expanding the work of the committee. This year so far (September 1959 through February 1960), 65 projects have been placed in public and private schools in the Baltimore metropolitan area. All 65 have been assigned to and will be completed by the visiting committee, which includes Mrs. Elihu Allinson, Mrs. Leon Ashman, Mrs. Meyer Baylus, Mrs. Marvin Davis, Mrs. Marion Friedman, Mrs. Samuel Fox, Mrs. Abram Goldman, Mrs. David Hollander, Mrs. Raymond Rangle, Mrs. Isadore Sborofsky, Mrs. Eugene Schnitzer, Mrs. Milton Sherry, Mrs. Alvin Stambler, and the co-chairmen Mrs. Steinbach and Mrs. Kolodner. Any additional placements before the end of the school year will also be visited by this committee, who have enjoyed the school visits, finding them a rewarding experience.

Dr. Smith has written, "The work which the Woman's Auxiliary has done for MSMR has proven most valuable, and without it the Small Animal Classroom Project would be seriously handicapped . . . As might be expected, a number of projects (students') were entered in the Science Fair and several won prizes or honorable mention . . ."

There have been additional placements of animals throughout the state in areas which this committee cannot visit due to distance. The committee chairmen, past and present, feel it would be most helpful if the auxiliaries of the county medical societies would set up similar visiting committees, so that every project in the state could be covered.

## Financial Aid to Students

Margie B. Warrens

This year has been the busiest yet for the Student Aid Committee of the Baltimore City Auxiliary. Thus far 19 requests for assistance have been received. One was from a nurse in her first year of training at Union Memorial Hospital who was therefore ineligible for our help, since help is limited to the last two years of training. She was referred to other resources and was able to manage without us. Two Maryland Medical School

## National Auxiliary President Is Guest At Annual Meeting



Mrs. Frank Gastineau, president of the Woman's Auxiliary to the American Medical Association, will be the guest speaker at our annual meeting on April 20. A native and resident of Indianapolis, Indiana, Mrs. Gastineau is a charter member and former president of her state auxiliary. She has held numerous positions in the national auxiliary: director, 1950-52; third vice president, 1956-57; and first vice president, 1957-58, and has been outstanding in the organization and chairmanship of the A.M.E.F. Committee.

Our guest is the wife of Frank Gastineau, M.D., a dermatologist. Of their three children, one is also a doctor and assistant professor of radiology at the Indiana University School of Medicine. Another son is a broker and a builder, and their daughter, now a physician's wife, taught school before her marriage.



students applied for our help under the misconception that it was an outright grant rather than a loan. They withdrew their applications as we worked this through together. Another applicant was a pre-med student at Mount St. Agnes College who was referred to other resources for which she was eligible. One was from a Hopkins Senior entering McGill University's Medical School, and therefore ineligible. He, too, was referred to other likely resources for help. A group of ten University of Maryland Medical students referred by Dr. Dietrich Smith was not eligible because they were not yet in their junior or senior years. They were taken care of in other ways.

Four students were actual recipients of our financial aid this year. Two of these were chosen by their respective schools to be the first recipients of our newly established annual scholarship of \$250 each to the University of Maryland Medical School, and the Johns Hopkins University Medical School. Each young man was described as an outstandingly capable student in the upper third of his class, of fine character and integrity. One youth is from Baltimore and the other from River Forest, Illinois.

It so happens that the two young men receiving

loans in the amount of \$1,000.00 each from us, also effected an exactly even distribution between the Hopkins and the University of Maryland Medical Schools. It couldn't have been planned better! Each is a married Senior, dedicated to his profession, who came very highly recommended by professors, employers, physicians, business contacts, ministers, etc. These two were, of course, personally interviewed by members of the committee last fall—one group of four members interviewing the Maryland student last September 30th, and another group of three seeing the Hopkins student on October 21, 1959. Life insurance coverage was provided as security in each case. Following approval of both these requests by the whole Student Aid Committee which met on October 21st, promissory notes were signed by each student before he received his funds, and warm notes of appreciation were received afterwards. The Hopkins man has committed himself to begin repayments on September 1, 1962, at the rate of \$30 per month, and the Maryland man has set his date for starting repayments as August 1, 1961, at the rate of \$25 per month.

Considerable correspondence, phone calling, etc., have been involved in each instance, and separate folders have been maintained on each of our loan recipients to keep an accurate and orderly chronological record of all contacts.

This chairman has maintained a lengthy and regular correspondence with the first recipient of our help (May, 1959), a physician now in residency training at Mayo Clinic in Minnesota. He had previously repaid \$20. This year he has made four additional repayments, now totalling \$130, which leaves a balance of \$370 due by June 1, 1961.

Our loan aid for Medical Technologists was listed under Maryland resources in a pamphlet recently put out by the National Committee for Careers in Medical Technology, and we are now also listed with the A.M.A. Committee on Medical Scholarships and Loan Fund Programs, as a Maryland resource for students.

Our funds have already been increased \$354.69 this year from gift cards, repayments, interest, etc., before our big annual dance has even been held. Although, as detailed, we have currently awarded \$2,500 to worthy students in need of our assistance, our balance on hand as of February 4, 1960, was \$1,254.25.